# The experience and psychosocial needs of patients with traumatic fractures treated for more than six months at Doctors on Call for Service Hospital, Goma, Democratic Republic of Congo

[a] **Okonta HI,** MD, DHSM, MMed(FamMed) [b] **Malemo KL,** MD, M Med(FamMed)UL [a] **Ogunbanjo GA,** MBBS, FCFP(SA), MFamMed, FACTM, FACRRM, FAFP(SA)
[a] Department of Family Medicine & PHC, University of Limpopo (Medunsa Campus), Pretoria, South Africa [b] DOCS Hospital, Goma, DR Congo
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**Correspondence to:** Dr H I Okonta, e-mail: okonta@mweb.co.za

## Abstract

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**Background:** Trauma-related consultations, admissions and complications are the leading problems at Doctors on Call for Service (DOCS) Hospital, Goma, Democratic Republic of Congo, and yet no studies have been carried out to document the experience of long-stay traumatic-fracture patients in this hospital.

**Aim:** The aim of this study was to explore the experience and psychosocial needs of patients with traumatic fractures treated for more than six months at DOCS Hospital.

**Methods:** Six free-attitude interviews were conducted with purposively selected patients. The interviews were recorded with a tape recorder and transcribed verbatim, and content analysis was used to identify themes from the interviews.

**Results:** All patients could clearly connect the injury experience to severe pain that lingered on for weeks or months for some patients, accompanied by other symptoms such as insomnia, poor appetite and psychological symptoms. Most patients felt disabled, were abandoned by relatives or friends and experienced financial problems. Some benefited from the injury by way of strengthened marital links. Some patients complained of poor information about their illness and the management plan and did not appreciate the treatment from caregivers, while some disclosed their needs and expectations and appreciated the caregivers who showed interest in them.

**Conclusions:** The experience of long-term trauma has negative effects on the whole person of the patient, including his or her work and family, and some patients continue to suffer from the effects of the traumatic event up to six months later. The needs of patients suffering from trauma include reassurance by physicians and nurses, more information and participation in the decision-making process, regular visits from friends and family, and better bedside manners from caregivers.

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## Introduction

Trauma-related consultations, admissions and complications are the leading problems at Doctors on Call for Service (DOCS) Hospital, and yet no studies have been carried out to document the experience of long-stay traumatic-fracture patients in this hospital. At the time of this study, Goma and its neighbourhoods was going through a period of war and had just sustained extensive damage from the volcanic eruption of Mount Nyiragongo. Armed conflicts and road traffic accidents were rife and were the main causes of traumatic fractures in the region.[1]

It was observed that in DOCS Hospital, some patients with fractures spend several months on admissions and after discharge keep coming back to the hospital for months of physiotherapy. Some of these patients spend a whole year or more in treatment and rehabilitation without working, as they are physically incapacitated by the fracture injury. Their conditions become chronic with physical, psychological and social impairment. The principal researcher who was managing these patients observed that some of the patients are forced to spend more time than expected in the hospital, far away from their families, while others have to relocate their families in order to have access to both hospital care and family support. It was also observed that some patients delayed accessing hospital care due to reported lack of money and by the time they turned up for treatment, their fractures had fused in improper positions, thus requiring longer and even more expensive interventions.

A fracture is a break in the structural continuity of bone. A traumatic fracture is a fracture due to excessive force applied to the bone. The external force can result from direct violence or indirect violence.[2]

## Understanding the trauma

When a patient suffers trauma, the presenting symptoms start during the traumatic event. Some of these symptoms disappear completely, but others linger on and may last much longer than normally expected.

Studying the fracture as 'bone disruption' is a reductionist approach. In a biopsychosocial approach, the family physician analyses the whole event in its three dimensions: the clinical, psychological and social impacts.[3]

The main clinical presentations of patients with fractures are pain, swelling and functional impotence. The physical examination may show a localised tenderness, shortening or other deformation of the limb in rotation, adduction and so forth. The X-ray will generally confirm the fracture.

The traumatic event, like any other illness, engenders personal experiences that are peculiar to the patient. These include the ideas, fears, concerns and expectations generated by the fracture. The patient's mental health will be affected, depending on the type, intensity, extent and duration of the traumatic event. The dynamics within the patient's environment (the family, community and work) will also be affected. Psychosocial dimensions must therefore be explored and included in the management plan.[4]

The purpose of all injury care is to restore the patient's pre-injury functioning and to facilitate the return to normal activity.[5] Often, however, fractures are not healed completely after treatment and patients have to receive physiotherapy and other forms of rehabilitation on an ambulatory basis. At this point, some patients realise that they will not recover the full functioning of the affected limbs. The Trauma Recovery Project, a large prospective epidemiological study designed to examine multiple outcomes after major trauma, showed that the quality of well-being at discharge and thereafter is significantly lower in trauma patients.[6] One qualitative study showed that most patients were not able to resume their previous work, except for those with non-manual labour livelihoods.[7] Another qualitative study found that trauma patients may suffer from psychological symptoms due to loss.[8]

## Methods

***The aim of the study was to:*** To explore the experiences and psychosocial needs of patients with traumatic fractures treated for more than six months at DOCS Hospital.

A descriptive qualitative study was conducted using free-attitude interviews for data collection. The study population was patients with any fracture treated at DOCS Hospital for more than six months. The main inclusion criterion was the patients' ability and willingness to describe their experiences. Patients who were unable to express themselves, such as children and patients with hearing or speaking disabilities, were excluded. Signed, written consent to participate in the research was obtained from each purposefully selected patient after going through the participant information sheet, explaining the nature and purpose of the study to the patient. Patients were interviewed individually, using the exploratory question: "You were fractured and treated for more than six months. Can you tell us what your experience with this illness was?" The interviews were conducted from 4 January 2004 to 3 April 2004 and the duration of the interviews ranged between 50 and 90 minutes. Data saturation was reached after the sixth interview. All six interviews were audio-taped and transcribed verbatim in French, and thematic analysis was used to identify themes from the interviews. For each interview, a relative who was the main caregiver of the participant during the illness was interviewed separately to validate the data. A senior family physician with experience in qualitative research independently listened to all the audio-tape recordings, read the field notes and transcribed the texts for agreement on the categories used in identification of themes.

Ethics approval for this study was obtained with clearance certificate number MP70/2003 from the Research, Ethics and Publications Committee of the University of Limpopo, Medunsa campus, and approval to conduct the research was also obtained from the Director of Goma Health Zone, Democratic Repulic of Congo. Written, informed consent was obtained from participants and all information volunteered was treated in strict confidence by restricting data access to the researchers and avoiding the use of participants' names in the interviews and transcripts.

## Results

Six participants, consisting of five men and one woman, were interviewed. The ages of the participants ranged from 21 to 59 years, with a mean age of 39.17 years. Four participants were married, one was single and one was divorced at the time of the injury.

### Thematic analysis

The following themes, with their supporting quotes, emerged from the interviews:

#### Theme 1: The injury experience

All participants could clearly recall the injury experience. They discussed the events that led to the injury: "The armed bandits looted my village, entered my house and shot at me."; "… the man wilfully hit me with his motorcycle."; "I became unconscious when the stone broke my leg."

They suffered severe pain following the traumatic impact of the injuries sustained, as reflected in the following quotes: "I have never experienced so much pain before."; "I did not know what to do since the pain was so bad … even drugs could not relieve it."

For some of the participants, the pain lingered on for months: "... currently I am still experiencing pain."; "I spent almost two months without sleeping due to pain."

In addition, for some of the participants, the pain was accompanied by insomnia and poor appetite: "The pain disturbed my sleep."; "Because of the pain I had no appetite."

Some participants had disturbances of cognition and mood while others found life to be meaningless as a result of the traumatic fracture: "I had difficulties with remembering since the accident."; "Sometimes I want to commit suicide because life is meaningless."; "I despair, found life to be useless …"

Some participants felt guilty, accusing themselves of being responsible for the trauma event: "This is my fault; I got into trouble because I offended God and this fracture is a punishment."; "I did a lot of harm to people and God that is why I got fractured."

Some patients were emotionally disturbed by the long stay and immobility and they feared amputation of their limbs: "It was annoying to stay in bed for three months."; "The immobility negatively affected my mood."; "I feared amputation of my leg."

### Theme 2: Disability experience

Almost all the participants felt disabled by the fracture that led to loss of job, inability to make a living and loss of independence. This is reflected in the following quotes: "I lost my job ...."; "Because of the cast I could not move myself; people had to lift me."; "… but now I cannot farm and cannot earn."

### Theme 3: Disturbances in social relations

Most participants experienced disturbance in relationships with family members or friends: "My wife is putting pressure on me because I cannot satisfy the family needs; I am afraid she might divorce me."; "My husband abandoned me because of this fracture."; "Most of those we considered friends have abandoned us, and our relationships are cooled with them."

Some families benefited from the injury by way of strengthened marital links or by being wiser: "This accident strengthened our marital links."; "My life will be better than before; I will be wiser in my actions."

### Theme 4: Caregiver interaction

Most of the participants were not informed about their condition and the management plan and were therefore not part of decision making; "They did not inform me how long the nail will stay in my bone."; "If I was informed about the duration of my hospital stay I would manage my financial resources accordingly."

The negligent, uncaring behaviour of caregivers was highlighted by some patients: "Some nurses do not care; you call for help but she did not care."; "Nurses neglected my complaints."

However, other participants appreciated the good care they received: "Doctors and nurses really cared for me."; "Their attention prevented me from an amputation."

Most patients disclosed their needs and their expectations of caregivers: "We need to get information about the steps of treatment."; "We appreciate the frequent visits by doctors."; "We need reassurance from doctors."; "Every patient with fracture needs the caregiver to talk to him gently, console him and to be kind with him in your response to his questions."

## Discussion

The injury experience is the most frequent theme that emerged from the interviews. Participants emphasised the circumstances of their trauma, the intense pain that ensued and the associated psychological symptoms they endured. This finding is consistent with the results of a phenomenological study in which similar responses were found in patients with fractures. The authors found the injury experience to be the most frequent theme in patients with fracture of the femur and hip.[9] However, contrary to our study, the patients in this study were interviewed two weeks after the trauma event when the memories could have still been fresh and symptoms still of high intensity.

All six participants in our study experienced pain with the injury, and for some the pain lingered on for months. The persistence of pain at six months after injury may be due to complications of the fracture and the 'pain of loss'. For anyone undergoing catastrophic change, it is the loss of the expected future that is grieved so deeply.[10] This deep grief can be a source of lingering pain. For our participants, the loss included loss of pre-injury functioning, loss of mobility, loss of power to earn a living, loss of career, loss of pleasing physical appearance, loss of self-esteem, loss of spouse and loss of friends. These are painful experiences that lingered on as unexplained pains attributed to the fracture. They also contributed to the associated symptoms reported by some participants: insomnia, poor appetite, amnesia, feelings of guilt, feelings of worthlessness and suicidal ideations.

The guilt reported by some participants appears to be due to distorted interpretation of the cause of their injury and misfortune. Some felt that it was punishment for the harm they had caused other people or for offending God. Such beliefs are common amongst rural Goma indigenes and are in keeping with the 'just world hypothesis', which asserts that people get what they deserve.[11] It is also similar to the karma of Buddhism, according to which the sum of a

person's actions in previous states of existence is believed to determine his or her fate in future existences, and therefore "nothing happens to a person that he does not for some reason or other deserve".[12]

The disability experience of participants reveals that most of them were unable to resume their previous work and some were still unable to perform the activities of daily living. The disability from the fracture resulted in loss of job and inability to engage in other gainful economic activities. This in turn led to or exacerbated pre-existing financial problems in the families, causing strain in family dynamics and interpersonal relationships with friends. A study that assessed the quality of life and functional independence of patients six to 12 months post hip fracture showed that most patients still showed some disability and had not returned to their prefracture lifestyles.[13] These results are consistent with the findings in our participants.

Disturbances in relationships with family members and friends emerged as an important theme in this study. Some participants came under constant threat of divorce from spouses who could no longer tolerate their incapacity to fulfil their pre-injury obligations as breadwinners. Others actually were abandoned by their spouses or their friends. These experiences are similar to those found in a study of the experiences of patients with chronic illness and disability.[14] In this study, it was found that high demands for physical care and support and changes in family roles sometimes result in marital breakdown. The study also found that tensions within the family may be exacerbated by unemployment, financial problems and a reduction in family resources.

However, the trauma event and disability strengthened marital links for some participants. These are patients who garnered robust family empathy and support during their period of illness and incapacity. Others learnt 'good lessons' from the injury and became wiser in the sense that they now know who their true friends are or that they realise how they could have avoided the trauma.

Lack of information about their illness and the management plan and negligent and uncaring behaviour by caregivers were sources of dissatisfaction for most participants. While the patient wants the best and most modern treatment available, he or she is also badly in need of the old-fashioned friend that a doctor has always personified and must continue to be. This 'doctor as a drug' was not there for most of the participants.

## Study limitations

This study has two major limitations. Due to its qualitative nature with a small sample, the findings cannot be generalised. The principal researcher who conducted the interview was also involved in the management of the participants during their long stay in hospital. This might have resulted in the participants' not rendering detailed negative information about their interaction with caregivers and therefore led to 'information' bias. These limitations notwithstanding, the study revealed some psychosocial dimensions that need to be integrated into the management of long-stay fracture patients.

## Conclusions

The results of this study are in keeping with the findings from similar studies. Long-term traumatic fracture experience has negative effects on the whole person of the patient, including his or her work and family, and some patients continue to suffer from the effects of the traumatic fracture up to six months after the traumatic event.

The needs of patients with trauma include reassurance by physicians and nurses, more information concerning their illness and the management plan, and participation in the decision-making process. They also need regular visits from friends and family and better bedside manners from caregivers.

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