

Counselling the Arthritic Patient

— Rôle of the general practitioner —

By Bruce L W Sparks

KEYWORDS: Patient Education; Patient Participation; Arthritis; Social Adjustment; Handicapped; Self-help devices; Self-help groups.



Curriculum Vitae

Dr Bruce Sparks, Secretary of the National Council of the Academy and Chairman of the Southern Transvaal Region, is also National Secretary and examiner for the MFGP for the Faculty of General Practice of the College of Medicine of S A.

He is a part-time member of and teacher in the Department of Medicine of the University of the Witwatersrand and works in a four-man general practice setting in Johannesburg.

Dr Sparks is married with two children and has special interest in: family therapy, sexology, doctor-patient relationship and the consultative process, computer technology - especially in medicine, plastic surgery, music, model making, general collecting - especially books.

Dr Bruce LW Sparks MB BCH(Wits) MFGP(SA)
2 Cruden Bay Road
Greenside
2193
Johannesburg

Summary

In a busy general practice the management of the arthritic patient is often limited to the control of the symptoms and the disease process, with very little counselling or discussion about important issues and hardships in the daily life of these unfortunate individuals. In this paper suggestions are made to improve communication in arthritis management and advice on sexual problems, home appliances and aids, community based agencies, psychological stress etc. is given.

The basis of counselling any patient is the appropriate and effective use of communication. **Communication** is defined as

“an interchange of thoughts and opinions — a process by which meanings are **exchanged** between individuals through a **common** system of symbols, which could be by language, signs or gestures.”¹

In other words, there must be some form of interchange through a language common to and understood by all the parties.

An American tourist in a Madrid restaurant wanted to order steak and mushrooms. He spoke no Spanish and the waiter knew no English. The diner drew a picture of a mushroom and a cow. The waiter brought him an umbrella and a ticket for a bull-fight.

Counselling the arthritic

For efficient communication we must be on the same wavelength.

MODES OF COMMUNICATION

In the doctor-patient relationship the form of communication varies according to the mode of the interaction.²

The active-passive mode. Here the doctor assumes total authority and the patient does not actively participate in his treatment. This form is generally applicable to the emergency situation — such as the severely injured motor-accident victim.

The guidance-co-operation mode. In this mode the doctor still exercises considerable authority but the patient is expected to co-operate — this co-operation being a factor in determining the outcome. This situation applies to most acute disease such as pneumonia and following most surgery.

The mutual-participation mode. Here the patient is expected to be actively responsible for his treatment. This applies to the management of chronic disorders such as arthritis. The doctor works in a collaborative way with the patient and must use persuasion, and not his authority, to obtain the results both he and the patient desire. The patient should be encouraged to take as much responsibility as is appropriate for the stage of the disease and the level of understanding of the patient. In order to achieve patient compliance in this mode, adequate education of the patient about his disorder is required.

FAILURE OF EFFECTIVE COMMUNICATION

Obviously, if the doctor who is treating an arthritic patient assumes the incorrect mode, by being more authoritarian than the circumstances warrant, failing to inform the patient adequately about his disease, or not involving the patient in the management of the condition, then failure of effective communication and compliance will occur.

So often the doctor, by using the incorrect mode and treating only the disease process, fails to elicit from the patient the areas of genuine concern regarding general health and problems of daily living. This situation is more frequently seen in out-patient departments than in general practice. The doctor may find it simpler to repeat previous therapy automatically and leave the management of any queries or problems to another doctor on a subsequent visit or to the consultant the patient will be seeing for the 6 monthly check-up.

For efficient communication we must be on the same wave length.

Thus, many real and troublesome problems not directly related to the blood count, glossitis, albuminuria, or gold dose, are neglected. If the patient were to complain of tiredness this would immediately result in a massive battery of tests among which marginally abnormal findings could lead to further tests and then ultimately result in a non-existent Ulysses syndrome, and unwarranted stress. With discussion and meaningful communication the doctor could, for example, have uncovered a depression related to an inadequate sex life, resulting from stiff and painful hip joints.

IMPROVING COMMUNICATION

What can be done to improve communication and bring confidence, compliance, and a holistic approach to the management of the arthritic and his or her family?

Within the therapeutic relationship there are four major factors to consider, the patient, the doctor, the disease and the consultative process.

THE PATIENT

Many events in our lives threaten our health, self-image, or life itself. The patient who consults the doctor because of pain, discomfort or disability, is acknowledging that he is not as self-sufficient as before.

To avoid a state of crisis, all of us need to have:

- a sense of physical well-being
- adequate self-image
- some control in everyday life functions
- the ability to be creative and productive in a way that is meaningful to us and accepted by others
- membership in a supportive community.

These aspects are severely threatened in an arthritic patient. A state of crisis often occurs with some or all of the classical stages:

DENIAL "It's not arthritis, I've just strained myself or have too much acidity"

ANGER "Why me"

BARGAINING "Maybe if I gave up running or ate less acid it would go away"

DEPRESSION "I feel so miserable and useless..." and then the ultimate stage of

ACCEPTANCE This may occur.

Each time a new joint is affected or therapy fails, a new crisis is often precipitated, with some or all of the above stages.

The general practitioner must be aware of the crisis the patient is experiencing and its stage through effective communication, intervening where necessary and encouraging the patient with empathy through each stage. Unfortunately, psychotherapeutic intervention often only occurs after the crisis when the patient has become dependant on alcohol or drugs, remained in the depressive stage, or experienced more severe emotional disturbance.

The basis of such intervention is adequate, effective, appropriate and meaningful communication. When doctors or nurses fail to communicate openly they become part of the person's problems rather than a source of help.

In managing chronic disorders like arthritis, the patient must be actively responsible for his treatment.

It should also be remembered that the patient's assessment of pain and the doctor's appraisal of it can be widely divergent. One reason for this is the misconception that in order for it to hurt, the patient must have an organic basis for his complaints — especially in chronic pain where the visible parameters such as sweating, crying, etc, are less likely to occur due to adaptation.

THE DOCTOR

What constitutes a good doctor?

A recent study at the San Antonio Medical School in Texas³ indicated that only one trait, the need to understand, to seek cognitive closure, is correlated with physician excellence. In the management of all conditions (not only arthritis) the doctor should be approachable, non-judgmental, and willing to listen. He should also show loyalty to his patients, including the ethic of medical confidentiality. This loyalty is an important factor in establishing a basis for the high level of trust desirable within a relationship.

The general practitioner, by the very nature of his calling as the practitioner of the whole person, should involve himself in the counselling of the patient with arthritis. Regrettably, in one survey conducted amongst patients in the R S A⁴, it was found that 10% of patients felt that doctors were frustrating because of their lack of understanding, encouragement and sympathy, their lack of knowledge about arthritis and because the doctors made them go to hospital. One point to emerge was that

The doctor should know how this disease affects the daily lives of the patient and his family.

doctors should be more aware and better informed about the arthritides. They also felt that the doctor should spend more time advising arthritic patients. General practitioners tend to be guilty of this, perhaps as a result of familiarity breeding neglect and indifference. The unusual and possibly significant symptom can often be ignored or glanced over due to a pre-fixed assumption that the patient-cum-friend of 20 years' standing is "always complaining of something", or a feeling that to begin pursuing what appears to be a minor problem to us, could result in an involved and time-consuming session — time being a commodity which is all too scarce in a busy South African practice.

The general practitioner may also feel threatened by the patient who has been exposed to many professionally trained individuals both privately and at special clinics, and often reads extensively around the subject in an attempt to find the "ultimate cure". She/he could well know much more about their condition than the general practitioner. The teaching of the arthroses was a very confusing and limited area of my undergraduate curriculum. We were certainly not taught to counsel in general, let alone the arthritic.

Persuasion and not authority should be used.

Exasperation and frustration also play a part in the doctor's attitude as he has "tried every drug and nothing helps" this relatively incurable condition. Yet the patient cannot accept this irreconcilable situation.

The cost of private investigations and drugs also hinders the adequate and effective management of many of his patients — especially the elderly — who make up the majority of the cases and where he may well use inappropriate but cheaper methods.

THE DISEASE

Apart from an adequate working knowledge of the arthritides, their specific management and complications, it is imperative that the family practitioner (in his total holistic care) should also know how they affect the daily lives of the unfortunate individuals who suffer from them and their families, and also what to advise or where to refer them for assistance.

I feel it is important that, apart from asking pertinent questions, the general practitioner should visit the home of the severely affected patient at least once and assess the conditions and activities with which the patient is faced. To see these circumstances and to assess where the patient can be helped, is of great value to the victim and the doctor managing the case. He can then refer them to the appropriate agencies for assistance or sometimes make very simple suggestions in order to make their lives easier.

Occupational therapists and social workers attached to the department of social welfare, will visit the homes of the patients to assess the situation and even arrange for aids such as fitted hand-railings, wheel chairs and devices etc.

Many simple devices are available commercially or can be manufactured simply and cheaply, eg aids for bathing, personal hygiene, kitchen aids, eating aids, activities and sports aids, reading aids.

The occupational therapy departments at the major hospitals can be of great assistance in this regard. Another agency in Johannesburg is the **Happiness House Independent Living Centre**, (Loveday St., Braamfontein, Box 7289 Johannesburg Tel: 724-3225). Here aids and apparatus for any disabled individual are on display and demonstrated by fully trained staff. The **National Arthritis Foundation** (c/o Dept of Orthopaedic Surgery Room 4M05, Medical School, 7 York Road, Parktown 2193 Tel: (011) 647-2346) has offices throughout the country and will advise on local agencies. They also hold regular public meetings where many patient-problems are discussed. Booklets are also available.

The importance of dressing warmly, gentle exercise, heat therapy, posture and lifting and bending techniques must be stressed.

The juvenile arthritic needs very special counselling.

A special area where intense counselling is required is in the case of the juvenile arthritic and his family. Here the poor child often has to cope with severe limitation of activity while attempting to pursue the development of a "normal" child. It can be heart-breaking to care for such a child and the parents require compassionate assistance through the recurrent pyrexias, joint pains, anaemias and dyspepsia.

SEXUAL COUNSELLING OF THE ARTHRITIC

I believe the doctor has a unique and obligatory role to discuss any sexual problems which may exist with the patient irrespective of his or her age. Too often the doctor assumes that there is no problem since the patient has not broached the subject. The family practitioner should ask whether there are any sexual or relationship problems as part of his general enquiries.

Sexual satisfaction and feelings of sexual adequacy play an important rôle in the ability to adapt to arthritic disability and foster feelings of worthiness and productivity.

Chronic arthritis of any aetiology may have adverse effects on sexual functioning. The most common problem encountered is mechanical limitation on coital positioning, which is usually as a result of hip disease — more troublesome in women than in men and more pronounced in bilateral involvement. I believe the sexual history should be a factor when planning the optimal time for hip replacements.

Mechanical problems can also be as a result of contractures and painful swollen joints — obviously the missionary position would be difficult for a man with painful knees, elbows and hands.

With arthritic patients, sexual adequacy plays an important role in their feelings of worthiness and productivity.

Sexual limitations can also be imposed by non-specific symptoms of rheumatoid arthritis (and some other arthritides), including weakness, general fatigability, vasomotor disturbances, numbness and tingling of hands and feet, and muscular atrophy. In fact a study has shown that the limitation of sexual activity is correlated more closely with the activity of the disease and not the severity of joint deformity⁵.

Although the limitation of motion occurring early in rheumatoid arthritis is due to pain and inflammation, later it is due to stiffness and fibrous ankylosis. The stiffness may be least in the early morning and thus it would be useful to coincide sexual activity with the optimal time of day. The use of hot showers, baths or compresses prior to sexual activity may help. Sharing a warm bath could become part of sensual play combining both therapy and pleasure.

If there is mild to moderate limitation of coital positioning, couples will often benefit from simple suggestions about how to minimise weight bearing and joint motion. For example, when a woman is unable to abduct and externally rotate her hips then rear entry coital position may be employed. If it is a man with hip disease a lateral, or woman astride position, may be useful.

The patient may also require reassurance that these positions are totally acceptable and that no position is "kinky" and that, provided mutual pleasure is obtained, anything goes! A few months ago a 50 year old arthritic woman, referred to me for sexual counselling, had been told by her previous doctor to "forget about sex and find something else to interest you."

Any patient consulting a doctor is acknowledging that he is not as self-sufficient as before.

A foot board to the bed often assists where there is weakness as may the use of rougher winter sheets. A waterbed is of great value as it facilitates "locomotion without commotion". In more severe cases of mechanical limitation, corrective surgery may be required to restore adequate opportunity for sexual functioning. Other poorer options may have to be suggested such as mutual masturbation or the use of vibrators or dildoes. It must be remembered that pain in one partner may well

produce impotence or inhibited sexual desire in the other through pity, guilt or anxiety.

Sexual dysfunction may be a result of genital ulcers and discharges of other rheumatoid diseases such as Sjögrens syndrome, SLE or Behcet's syndrome. Lupus can result in uraemia and its attendant sexual difficulties.

It should also not be forgotten that many arthritic patients may also suffer from hypertension, atherosclerosis, uraemia, anaemia, etc — all potent causes of inhibited sexual desire or performance.

THE CONSULTATIVE PROCESS

The fourth aspect to consider when attempting to facilitate communication, is the consultative process.

I have already made mention of the modes of the consultation and how using the appropriate mode in discussing the patient's condition may facilitate better appreciation of the problems.

The important aspect to appreciate is "the rôle of the doctor as the therapy". So often, when a patient presents to a general practitioner, nothing new can be offered to the patient. It is important to stress that fact to the patient and not proceed to prescribe a new anti-arthritis. Reassurance that the condition is not deteriorating, and discussion about any problems, is all that may be required. Knowing that some-one out there cares, is often enough.

If we as classical general practitioners are to maintain our credibility against a plethora of dieticians, faith-healers, "health food" producers, homeopaths, and other fringe "professionals" of dubious abilities, then we must gain the faith and respect of our patients by a holistic approach to them and their families — not only through curative, but also preventative, promotive, comprehensive and continuing care.

James Spence, the famous paediatrician, said:

"the real work of the doctor is not an affair of health centres or public clinics, or operating theatres or laboratories or hospital beds. These techniques have their place in medicine, but they are not medicine. The essential unit of medical practice is the occasion when, in the intimacy of the consulting room, or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it."⁶

References

1. Webster's Third International Dictionary vol. 1. Chicago: William Benton, 1966; p 460.
- 2/3. Bowden CL, Burstein AG. Psychological basis of medical practice 2nd ed. Baltimore: Williams & Wilkins, 1979.
4. Medical Services Division, Market Research Africa. Report on an Arthritis Patient study conducted for Lederle Laboratories, Johannesburg Feb 1983.
5. Herstein A, Hill RH, Walters K. Adult sexuality and juvenile rheumatoid arthritis. *J Rheumatol* 1977; 4: 35-9.
6. Court, SDM. Medical care of children. London: OUP, 1963.