Opsomming:

'n Meer volledige beskouing van "chroniese siektes" wat deur huisartse dikwels misken word, word aangebied. Die belangrikheid van hierdie toestande word aangetoon d.m.v. voorbeelde vanuit die praktyk en die verantwoordelikheid van die huisarts word beklemtoon.

The management of chronic disease in general practice

DR. J.H. LEVENSTEIN

THE MANAGEMENT of chronic diseases is one of the specific areas that fall within the compass of the general practitioner. In fact the Royal College of General Practitioners list it together with acute diseases, diseases which have early recognisable signs, diseases which have preventable complications and common diseases as one of the most important diseases a prospective general practitioner must have training in.

It is however an area which is usually avoided and often ill understood, especially within the context of general practice. Reactions often include, "He's a chronic — nothing I can do for him". These "chronics" do not allow us to "cure" them. These "irritating" patients keep returning underlining our impotence and helplessness.

Estimates of chronic illness, injuries or impairments in the population from an Australian study show that 230 per 1000 in the population (ie. 23%) suffer from one or more such illnesses. Of these 90 are limited in their activities and 50 are substantially handicapped.

Fry, that doyen of general practice epidemiologists, records 487 (19%) persons with chronic organic illness, in a practice of 2500 persons, consulting per year. The commonest conditions being arterial diseases, eg. hypertension, coronary artery diseases — 115 persons, "rheumatism"

— 115 persons, "rheumatism" — 100, mental illness — 60, chest diseases — 55, obesity — 40 and cancers — 30.

It is interesting to look at the high number of 628 persons (ie. 25%) consulting in a 2500 person practice for "social pathology". The majority of these too have chronic conditions. These problems are found among the elderly, the poor, the alcoholics, delinquents, one-parent families, etc. and are inevitably of a chronic nature.

It has also been shown that this mass of chronic morbidity is not due to the aged. Numerically by far the greatest number of people suffering from chronic illness are in the working age group. Thus while the aged, which make up 8-10% of the population, have a greater incidence of chronic illness, numerically there are far more disabled among the younger age groups.

What in fact is "chronic illness"? Implicit in the diagnosis is an inability never to "cure" the condition — the patient will either die from the illness or die with it. From a management point of view the patient requires continuing care and observation. Continuing care is what general practice is all about. The general practitioner is seeing all his patients longitudinally over their life-span so consequently he is in an ideal position to manage these conditions.

Furthermore, his need to label a condition "chronic" in the strictest sense of the word is not really so relevant. For example, a disordered personality can potentially "disable" a patient for life. It may certainly result in more frequent consultations as the patient encounters through his world, more stress situations and consequently a greater inability to cope. A knowledge of this patient's problem should be ever present with the general practitioner and his management should take account of it. A highly independent patient will have a "chronic" aversion to consult his doctor using strong denial mechanisms in order to prevent interference with his life style. A doctor will again have to be aware of this throughout, educating wherever possible — using his limited exposures to the patient to give him (the patient) insight to his attitudes etc.

The point I am driving at is that the majority of patients have problems whether they be physical, psychological or social that are with them for the whole of their lives which disable them to a lesser or greater extent. These all require continuing attention so that the patient may be better able to cope with life. The general practitioner with his vast data

base on patients and their families and his frequent exposure to them is thus ideally equipped to manage and support the patient throughout. This management must be tailored to the individuals needs intervening where appropriate, foreseeing and thereby preventing problems or complications in that specific patient.

The management of chronic illness thus requires continuing and preventative care of all aspects (physical, psychological and social) of the patient's problems. It is not the management of an illness per se but the management of a patient.

Let us take a few examples of "chronic" disease in patients to illustrate points in general practitioner management.

A 43 year old patient is diagnosed as having essential hypertension during routine **screening,** having initially consulted for a sore throat. It is important to realise that this is a **doctor imposed** illness. The patient has unexpectedly been told that he has a life threatening disease for which he will probably have to take pills for the rest of his life. The General Practitioner will have to **know** much about the **patient's personality and behaviour** if he has to get maximum compliance. The patient should be allowed to verbalise his perceptions of what this means to him. A patient's fears, anxieties and denial mechanisms should be explored. The doctor should provide information **(patient education)** in an attempt to get the patient to realise the positive benefit of compliance. **With easy and regular access to the general practitioner** the job of therapeutically stabilising the patient begins. Careful note is taken of side effects of drugs. Ignoring the patient's feelings can only result in non-compliance.

Individuals react peculiarly to drug therapy of any sort with regard to dosage, tolerance, side effects. All medicines should be **elegantly administered,** proceeding slowly, adding, substituting or removing where appropriate.

Hopefully, the general practitioner will be **preventing** both the incidence of acute heart attacks and cerebrovascular accidents.

With regard to the latter is it thought that each 8 years continuous anti-hypertensive treatment prevents a stroke among your patients while the possible decrease in acute heart attacks, especially with patients on beta blockade, is gradually being confirmed in the literature.

It is estimated that well over 90% of patients will consult their general practitioner within a five year period so at no extra cost to the community this important screening task can be fulfilled effortlessly.

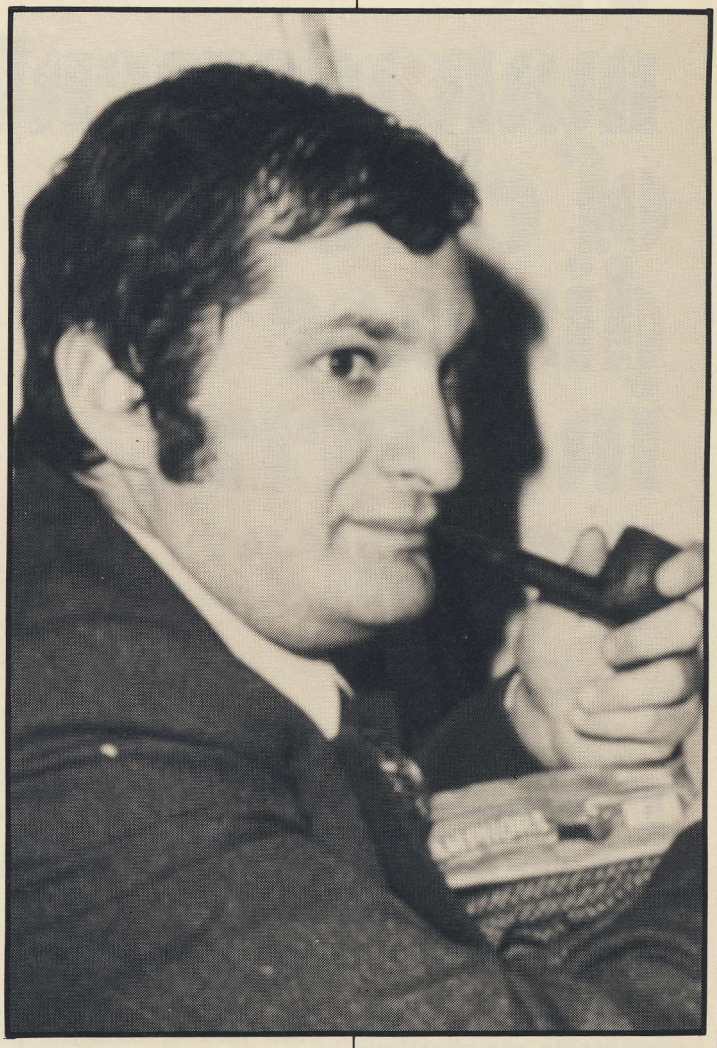
A 39 year old executive admits to you that he is "probably" drinking too much. The consultation has come about as a result of his wife having brought their 11 year old son who has become aggressive and is performing poorly at school. You look for a **stress situation** and it turns out to be marital discord in the family. The wife admitted to being depressed saying that her husband had become more and more distant of late and was "drinking more than was good for him". Thus, this most chronic debilitating disease of all is uncovered by the general practitioner who is aware that **illness affects families and families affect illness.** Concentrating on the problem of alcoholism for the moment the general practitioner must have learned to cope with his own feelings (self-awareness) on the subject to be able to manage this problem, his feelings of inadequacy at being unable to cure it, his feeling of anger and resentment at the relapses etc. His attitudinal approach to the patient has to be non-judgmental, for example, to allow the patient to return for treatment following a relapse etc. This is a situation which has to be managed in all its physical, social, psychological and community aspects with the general practitioner, the leader of the team.

A 53 year old man admits to getting retrosternal pain on walking up a flight of stairs. Previously he only gets angina if he rushed up the stairs. This represents **a deviation from this individuals norm** in his chronic illness and he is at a risk of an acute heart attack. The patient has been **educated** to inform of any such deviation. Up till now he had accepted the limitation of his illness and also accepts the significance of this change.

Change, any change, in chronic illness needs attention. This change can result from any **stress situation** whether it be physical, infection, psychological eg. bereavement or social eg. loss in earning power. An awareness of this and even an anticipation of this can help both you and the patient to manage and cope more effectively with the problem.

Finally, one should look at every crisis eg. suicide or major physical incident eg. myocardial infarction, as a possible failure of continuing care in the "chronic" patient. This concept of **self-audit** will help to tone our skills in patient care.

It is thus seen that if we accept that we manage our patients continuously or longitudinally and most patients are disabled to a lesser or greater extent by physical, psychological or social problems, the management of chronic disease becomes merely the management of patients not illnesses. The skills required are those basic to general practice including an awareness of the patients and one's own behaviour. Attention to detail for example turns an acute confusion in an elderly chronic to a search for the change physical, psychological or social that has precipitated this event. A knowledge of the natural history of diseases and appropriate careful intervention are essential to good care as are a willingness to listen and an understanding of the patients coping mechanisms. Finally, an awareness that some conditions we cannot cure, and the patient with rheumatoid arthritis for example, will cope better with his chronic disabilities if we are able to cope with our inability to "cure".



ABOUT THE AUTHOR:
Secretary: Faculty of General Practice
Chairman: Research Committee — Faculty of General Practice
Head: Unit of General Practice — University of Cape Town
Vice-President: WONCA
Chairman: Emergency Call Committee, WONCA.