

REPORT

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Psychosocial Aspects after Myocardial Infarctions, By-Pass Surgery and Angioplasty and the Quality of Life: What to Tell the General Practitioner.

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This was an important meeting; cardiologists, a cardiac surgeon, psychologists and psychiatrists came together to discuss the influence of psychosocial factors on the outcome of treatment of patients at defined points in the natural history of ischaemic heart disease. They examined the known data on the effect of psychological and social methods of intervention. By including a session on quality of life they acknowledged that a cardiac rehabilitation programme may not prevent another infarction or reduce the risk of dying from cardiac disease; a more realistic goal is to promote healthy and successful adjustment in patients and their families after the major events, myocardial infarction and elective surgery. Thus the meeting represents a major shift in emphasis in response to an increasing body of knowledge on these aspects of care.

There was considerable agreement on the incidence and type of psychological problems encountered in these patients. Anxiety and depression is common though in the great majority does not amount to severe disturbance. When present to a significant degree it results in a poor outcome whether measured in clinical terms, social functioning or psychological adjustment. The participants approached measurement of these aspects in various ways depending on their particular background. They also advocated a wide variety of methods of intervention. Some were highly sophisticated and obviously more suited to research work or for a few highly selected patients rather than of use to the busy general practitioner.

Nevertheless there was a strong central theme throughout the meeting; the concept of individuality. The patient is an individual. He does not exist in a vacuum but has family and friends, may or may not want to work, may accept or reject his doctor's advice and will have his own idea on what the outcome of a particular method of treatment is likely to be. The general practitioner is also an individual. He will probably see only a few patients per year following myocardial infarctions and even fewer following bypass surgery and angioplasty. New methods of treatment may have been introduced since he qualified so he may feel very uncertain of how best to advise his patient. He may feel unsure about getting involved with aspects labelled "psychological" or "social" and prefer to avoid such issues; the results of a poll of local general practitioners by one of the participants tended to support this.

Experts in the field have a dual responsibility. They must inform the general practitioner of ongoing research and development but they must collaborate with him in the treatment of an individual patient. In both instances communication has to be in clear simple language without professional jargon. Communication has to be speedy; failure to do this quickly enough has resulted in undue delay in return to work after angioplasty and may in part account for some of the more disappointing social outcomes after bypass surgery.

Outcome of medical and surgical treatment of ischaemic heart disease cannot be 100% successful; in the absence of "cure" it depends on an optimal physical result (presence or absence of symptoms, functional capacity), psychological adjustment (morale, coping, well being, attitudes to health and illness, presence or absence of emotional upset) and social functioning (work, retirement, finances, family attitudes, leisure activities). The patient's expectations of the results of any therapeutic procedure must be realistic and his family must share in this. This is particularly important in the consideration for bypass surgery, an elective procedure. After an infarct or in relation to bypass grafting or angioplasty, assessment treatment and evaluation of intervention in all these aspects is what is meant by "quality of life". All can be identified and measured.

It must be stressed that there are simple ways to assess these factors clinically, that the general practitioner can do himself and that with his background knowledge of patient and family he can do it well.

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The crux of the problem is, how do we, as experts, inform the general practitioner? In the long term, undergraduate training should include thorough grounding in these aspects of care so that new generations of physicians become accustomed to dealing with such issues. As we become more involved in chronic degenerative disease such training is necessary not only in ischaemic heart disease but is appropriate in the management of patients with other illnesses.

For the present, education of the general practitioner should proceed at several different levels. In the management of the individual patients, it becomes the responsibility of the hospital clinicians to establish good lines of communication with the patient's general practitioner informing him of physical, psychological and social factors in each case, discussing possible treatment alternatives and letting him know what has already been said to patient and family. In some towns and districts it might be feasible to organise meetings with local general practitioners though there will be a limit to the number of meetings that a busy practitioner can attend. The danger of such meetings is that only those already interested will come. Booklets of information about the services available locally could be advantageous. The participants, recognising that such measures will not reach many general practitioners, came to the conclusion that there is sufficient knowledge of and agreement on basic methods of identifying and treating mild and moderate psychosocial problems to allow preparation of a booklet (not a text book!) which would be useful to the general practitioner. This booklet, with its emphasis on practical guidelines, should aim to be widely acceptable and could be complemented with information on which facilities and services are available locally.

Though discussions of what and how to tell the general practitioner was the main issue of the meeting other benefits accrued. There was considerable agreement between the members of the various professions, and "jargon" language barriers though still too often present began to disappear. Progress has been made in the last 10 years in the development of straight forward questionnaires to measure the soft date of psychological and social aspects of care. The problem now is too many questionnaires rather than too few. Many of the participants felt that methodological "housekeeping" was now necessary. Collaborative efforts with several centres examining each others questionnaires and aiming to produce guidelines on which measures were comparable might well result in a list of a few short questionnaires that would be suitable to screen patients in the service setting, identifying possible problem patients whose care might require specialist help and delineating areas of concern in the other patients, the general majority, who should be treated by their general practitioner. Improvement in measurement allows comparison of various methods of psychological and social intervention. While a great deal of work remains to be done, tangible progress has been made, the groundwork of future collaboration has been prepared and meantime it does seem possible to gather together what we already know in a form suitable to present to the general practitioner.