Teaching the Patient About His Chronic Pulmonary Diseases*

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When an individual is stricken with an acute illness such as appendicitis, he usually need only accept the diagnosis, give his permission for operation, take the anaesthetic and tolerate the surgical after-effects for a short time. This treatment is administered almost entirely without his conscious participation.

When a patient becomes ill with a chronic disease, on the other hand, it becomes essential that he participate consciously and wholeheartedly in his treatment, and for many months as well. The fact that treatment of chronic lung disease usually necessitates both active and passive participation makes it mandatory that he be educated about his disease. Education becomes all the more important when the disease is contagious, as with pulmonary tuberculosis.

The education of the patient with chronic pulmonary disease is a cooperative project, involving the doctor, the nurse, the social worker and, most important, the fellow patient.

The development of rapport between the staff and the patient is unquestionably the first objective and is of the utmost importance. It begins the day each staff member first meets the patient; it is a continuing project; it is undertaken in widely varying ways, depending largely on the personalities involved. While it is gratifying to be regarded as a good fellow by your patients, this approach can be overdone. On the other hand, there is the opposite tendency of some professional personnel who strive to achieve strict and prompt obedience. Strict discipline will help establish a neat and outwardly efficient hospital or clinic but not always a happy and successful one.

The subjects which should be stressed in such a patient education program are:

1. The mode of transmission of the disease (if infectious), and its prevention. For instance, we should encourage each patient to remind his fellow patient when he forgets to cover his mouth properly.

2. The anticipated future behaviour of the disease in the individual. Most patients appreciate a clear exposition of their problem and an estimation of their anticipated response to treatment. While harm can be done from excessive discussion of details, more harm is apt to be done by withholding pertinent information in the majority.

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3. The desire to get well. Motivation is a tricky subject, difficult to evaluate and even more difficult to arouse. Patient education can play an important part in stimulating motivation especially when the patient is unduly pessimistic about his prospects.

4. The prevention and control of fear of deformity, disability and death, which are thought to accompany thoracic surgery. A concise description of the operation to be performed will help. Arranging a chat with others who have had a similar operation may be invaluable.

5. The occasional unpleasantness of treatment. The treatment may be worse than the symptoms of the disease itself, especially after the first few weeks or months when symptoms may have abated. I have reference particularly to postural drainage, pneumoperitoneum refills, surgical operations, injections of various kinds and the taking of drugs (e.g. PAS) which may upset the stomach or cause other unpleasant symptoms.

The sequence of the problems as they are apt to present is as follows:

a. At Diagnosis. Here one must stress that the disease can be cured or controlled when there is good reason to believe this to be true. Of course, this optimistic point of view can be oversold in certain patients. One must also persuade the patient to accept treatment, which often seems far more drastic than appears justified by his feeling of ill health.

b. At entrance to the Hospital. Here he must be taught to accept a state of dependency for a time, that is, he must learn self-discipline. When certain drugs are begun for instance, the patient must be strongly admonished to avoid interruptions in their administration, except when approved by competent authority for good cause. This is also the point at which the patient must be persuaded to make sacrifices of time, comfort, convenience, even appearance if necessary, in order to get well.

c. Surgical Intervention. It is wise for the physician to start early, often months in advance, in preparing the patient to accept surgical intervention where this appears a probable eventuality. If circumstances change and no operation is required, no harm will have been done. In fact, most patients are pleased at such a favorable turn of events which can be laid to their credit. It is best to explain all procedures carefully to the patient; he often understands more than he is given credit for, even individuals without much of an education.

d. At Discharge from Hospital: Some patients do not want to be discharged, even though physically ready for this step. They have become so dependent that they do not wish to leave the comfort and security of the hospital and its staff. Some in this group were unhappy in their work or marital relations before becoming ill and are subconsciously unwilling to face these situations again. They can think of no alternative than to become reinvolved and unhappy once they leave; it is manifestly easier not to leave. Conscious and subconscious stratagems will be devised to avoid this threat. A comprehensive knowledge of the patient’s personal and social history and an understanding of his personality plus great patience and tact may enable the physician to deal effectively with this common and trying situation.
The methods of patient education consist in movies, film strips, lectures, group discussions, pamphlets and bedside consultations by various professional personnel. It is important to remember that a point may be put across by the printed word, or better still, in a group session, which may have been difficult if not impossible to transmit by other means. One may also succeed in this regard by speaking to one patient within another patient’s hearing, for the particular benefit of the latter.

Here are some do's and don'ts worth remembering:
1. Don’t rely upon one method of teaching.
2. Don’t rely upon one teacher. This is a cooperative job.
3. Do check up on the effectiveness of pamphlets and other visual aids. Ask the patients whether they have understood what they have read and what they have been told when they are interviewed individually.
4. Do use simple non-scientific language.
5. Don’t delay in starting patient education. It should begin immediately the diagnosis of chronic pulmonary disease has been made.
6. Do be truthful in informing patients or in answering their questions. This does not mean we should not avoid covering certain aspects of a problem which are better left untouched.
7. Don’t leave the educational process to the hospital staff alone. The physician at home can do a great deal to augment the patient’s knowledge about his disease and what he must do to protect others and to get well. On the other hand, the home physician may make use of the hospital as a “school” for his patients, especially for a few weeks or months at the outset of treatment.

In summary, teaching the patient about his chronic pulmonary disease is vitally important in its management. A good system to follow is first, to gain rapport with the patient, then pass out printed material; this should be followed by individual discussions at the bedside with the nurse, social worker and doctor. Then there should be group discussions including a question and answer period; this should be followed in turn by other bedside discussions. As the patient becomes ambulant, private discussions may be continued in the doctor's or social worker's office. From experience, it is clear that such a program is quite apt to fail in its objective unless there is considerable interest and enthusiasm on the part of the physician, no matter how interested the other personnel may be.