Personal Paper

Problems of immobility and pain

LOUIS HERZBERG

My main purpose is to sound a warning loudly and clearly. At all costs avoid active participation in parents' games at school or social functions. It is not until one encounters the almost woefully laughable problems of immobility and dependency after an accident in a Mums against Dads game of soccer that one realises just how often serious injuries occur in such social and charitable events.

The story really begins when I fractured my right cuboid bone, complicated by dislocation and subluxation of the mid-tarsal joint, while running gently with a ball at my feet. The pain was excruciating and I was unable to place any weight on my foot. Eventually I crawled to the touchline amid derisive shouts from equally dyspnoeic mums and dads, who thought my problem was simply one of exhaustion. The referee was an associate professor of surgery, a team-mate the professor of medicine, and the wife of an orthopaedic surgeon an opponent. The only person who noticed my agony was the completely non-medical wife of a doctor. She offered to drive me home.

For the next few days I sought relief from my "sprained ankle." On attempting to return to work three days later, however, the 10 minutes taken in moving from my car to my office was considerably longer than the normal maximum of two to three minutes. The pain and swelling prompted me to ask a friend in the accident and emergency department to examine the foot. After twice visiting the radiology department because the correct radiographs were not completed on the first visit I eventually had my leg moulded into plaster about four hours after arrival at work.

I was given a pair of crutches and told to rest my leg for a few days. I was probably actually told more, but pain and depression may have prevented my appreciating clearly the advice I was given. It emerged later that I would have been admitted to hospital for rest with a raised foot for three weeks had I been an uneducated labourer and had beds been available.

Crutches

As an undergraduate I had always disliked orthopaedic surgery since it was a very mechanical discipline—even more mechanical than my other *bête noire*, midwifery and gynaecology. Some people are just no good at mechanical problems. I am one of them, and I just could not adapt at first to using crutches, finding the continual pressure of the crutch top under each axilla increasingly difficult to bear. Apart from the localised discomfort I was concerned at the possible development of a brachial plexus lesion. I attempted to hobble around the house, experiencing severe pain whenever my foot touched the ground.

While manoeuvring my way round I slipped and fell more than once, breaking the frames of two pairs of glasses, including the "spare" pair I had obsessively obtained.

I thought it essential to remain mobile, partly because I had been warned that I might get a deep-vein thrombosis if I lay in bed excessively. But bed was the only comfortable place. I did not realise how extraordinarily tiring it was to get around on crutches, especially for a relatively unfit 41-year-old. Not only was the ball and chain phenomenon of a plaster cast up to the knee joint an enormous encumbrance, but the strange nature of propulsion on crutches produced aches and pains in muscles I had not remembered existed. My gluteus medius and minimus as well as my tensor fascia lata, which as we all know "abduct the femur and rotate it in," were extremely painful. My forearm supinators and pronators started to bulge, as did my triceps and biceps. The effort of lugging a 90-kg weight around produced muscular hypertrophy and extreme tiredness. It was easy to consider tiredness neurotic and psychosomatic, while the discomfort of touching the floor with my damaged foot was obviously an attention-seeking hysterical phenomenon.

Dependency

In all seriousness dependency is the worst problem for somebody who has relied very much on his own abilities before an incapacitating event—even if such reliance was delusional. The difficulty in making a cup of coffee—manoeuvring from the fridge to get the milk near the cup and the kettle—really became a major problem.

To get on with the work that needed doing I had to return for three days until my follow-up orthopaedic appointment. Ward work was obviously out of the question, and a colleague deputised. A specially arranged outpatient clinic, however, which had taken over a year and a half to arrange, presented a problem. With the aid of lifts, wheelchair, and the chauffering of a colleague I arrived at that hospital to be greeted with the news that the porters were having a meeting about going on strike. Yes, friends, this happens in Australia too. I was wheeled to the clinic whereupon I remain convinced I did more good for my patients that I have ever done in any other clinic. Their amusement and even obvious hilarity at seeing their doctor with his leg in plaster stuck up on a chair made them feel so much better than any drug manipulation or supportive and sympathetic psychotherapy I had ever been able to provide before.

There was the same amusement from colleagues and other patients when they saw me on my voyages round the hospital. The cancellation of attendances by private patients produced several interesting comments, such as "I thought these things never happened to doctors."

Possibly they assumed I knew what was best for my foot so that I did not spend weeks in bed with it raised. Accordingly, I have learnt once again the lesson that every patient should be treated as if they know nothing about the problem other than their symptoms—even if they are a world expert in the field.

Department of Medicine, Queen Elizabeth II Medical Centre, and Repatriation General Hospital, Nedlands, Western Australia 6009.

LOUIS HERZBERG, MB, FRACP, senior lecturer and consultant neurologist

Resting in bed and physiotherapy

The only other times I have spent the odd days in bed were after flu and one episode of bronchitis in 1969. Then I remember feeling terrible without any drive or energy. Mental and physical lethargy coexisted. These episodes exist in most people's experience and are short-lived. A broken foot does not usually have any associated psychic pain and is therefore accompanied by an intense sense of frustration arising from inactivity and dependency.

Some relief may be obtained by dealing with routine letters and administrative problems. A courier service was started between the hospital and my home. A tape recorder is a great help while the telephone still rings with patient and administrative problems. It is salutary to realise that one is not indispensable.

Although I had requested physiotherapy for years for patients, I know I believed that most of the time very little was actually achieved. I considered that the personality and interest of the physiotherapist together with the gentle laying on of hands were the important features. Those lesions that were going to improve would improve spontaneously in time, whereas those lesions which would not improve would not improve much. "Vix medicatrix naturae," the healing force of nature, was the prime element in improvement. On the other hand, I had always accepted that physiotherapists gave confidence, especially in range of movement and in walking. I have now learnt that an increased range of movement is obtained more readily by the passive movements of the physiotherapist than by one's own unaided movements, which are limited so much more by pain.

Will power could overcome the sensation of tickle underneath the plaster cast. This mechanism was nowhere nearly as effective with pain, even in the light of one's self-image of having a high pain threshold. There was no doubt that weight bearing and active movements at the mid-tarsal joint were, quite simply, painful.

Moreover, there was no doubt that, while rest with the foot raised diminished pain, aspirin diminished it to negligible or

zero levels. Unfortunately, swallowing repeated doses precipitated indigestion, just like the texts say it may.

Convalescence

Readjusting activities is vital, and I hope that some of my comments may help others to adapt to immobility. Particularly frustrating has been the inability to take exercise. Additionally, the extraordinary sensation of realising what happens during a morning in the office is quite revealing. I had no idea that I rose from my desk so often either to get something from a filing cabinet or the library or to leave a letter to be collected, or to discuss something with my secretary, or to go and make a cup of coffee. Even when sitting one makes subconscious movements, the absence of which leads to the development of the "numb bum syndrome." Suddenly one is faced with the sheer physical organisational problem of mobilising oneself on the crutches and hobbling round to the lavatory, where the stiffness of the door makes entry and exit quite a logistical problem. The dependency on other people for simple basic necessities is depressing. I write this having dealt with hemiplegic and paraplegic patients for 14 years. I write also in the knowledge that I have considered myself as a warm, sympathetic individual caring for patients with stroke, multiple sclerosis, cerebral tumours, peripheral neuropathies, and spinal cord injuries. There is really no better way of understanding the problems of disability than to experience these problems oneself.

I do not recommend that the undergraduate medical course include enforced or even iatrogenic illnesses to increase the empathy of future generations of doctors, but it is really chastening to be immobilised with a ball and chain in the shape of a knee-high plaster.

Never again will I enter an orthopaedic ward to advise on a medical problem with the same almost total lack of feeling and sympathy as I fear I have done in the past.

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A consumer's guide to "bionic arms"

TOM SENSKY

Anyone who watches television will have seen examples of the "bionic arms" made in Sweden and fitted to young children with congenital upper-limb deficiencies. These prostheses are not yet generally available in Britain but are under assessment. Does their design represent a real breakthrough? Do they effectively replace real hands functionally and cosmetically?

The "bionic arm," or more accurately the myoelectric hand, must be compared with the mechanical hand commonly supplied to upper-limb amputees in Britain. What follows is a review based on and biased by my own experience of growing up without a right hand and using various prostheses.

Parents are potentially their children's best observers and therapists, provided that they do not pay more attention to their own feelings than those of their children—and feelings of guilt and personal responsibility are recurrent themes in conversations with parents of handicapped children.

Quite naturally parents wish their child to be as "normal"

as possible and thus favour a life-like prosthesis, unless they are aware of the superiority of a split hook.¹ But a young child's body image is not that of an adult; he does not at first see himself as different from other children, or "abnormal" as adults might regard him.²⁻³ He pays little regard to cosmesis and is much more likely to accept a prosthesis that functions well.¹⁻⁴ The attitude of parents is of overriding importance, however, and a child may thus reject a useful prosthesis that he thinks his parents believe is unsuitable.⁵

A child without an arm grows up with this defect, which is thus incorporated into his body image.⁵ Early fitting of a prosthesis allows this too to be incorporated into the body image.⁴⁻⁶ This contrasts with the disintegration of body image after amputation, which calls for an altogether different psychological adjustment.⁷ This is one important reason why others fail in attempting to put themselves in the shoes of a child with a congenital deformity such as a missing hand; they can only imagine what it would be like if they, "normal" people, lost a hand. When necessary, parents should be helped to understand this. The attitudes of outsiders to a child's deformity will be much more favourable if they see that his parents, and later the child himself, are comfortable with his body image.

Department of Surgery, Stoke Mandeville Hospital, Aylesbury, Bucks HP21 8AL

TOM SENSKY, PHD, MB, paediatric house surgeon