The patient’s burden: physical and psychological effects of acute exacerbations of chronic bronchitis

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In this prospective qualitative study we evaluated the subjective perspectives of the quality of life of patients with chronic bronchitis. Individuals with diagnoses which fulfilled the clinical criteria of chronic bronchitis, i.e. daily production of sputum for at least three consecutive months in two consecutive years, were recruited into four focus groups from general practices in two industrial cities. Younger patients (those of pre-retirement age) of both sexes—a significant, but frequently ‘invisible’ minority in this patient population—were targeted. The groups were constituted with the aim of stimulating variation in the discussions. Twenty sufferers (10 males and 10 females, ranging in age from 30 to 86 years) were eventually included in the study; there were five in each group. Group discussions were recorded and transcribed verbatim and the data were analysed thematically. It was evident from the discussions that chronic bronchitis had led to a high degree of psychological distress in the participants, particularly in relation to dependency on medication, and disruption of social and family relationships. Acute exacerbations of chronic bronchitis (AECB) were met with dread. They brought about further reductions in quality of life, increased anxieties about breathlessness, fear of atmospheric pollution and of changes in and extremes of temperature, embarrassment about coughing up phlegm in public and suspicion of medical practitioners’ motives if they were unwilling to prescribe antibiotics on request. Patients’ health-related behaviour and beliefs were often contradictory. For example, AECB in some patients led to increased smoking. There were also gender and age differences; for example, it was the perception of males that they received more support from their partners than did females. Younger participants appeared more distressed by AECB than older ones. The results of this study suggest that raising the standard of care for patients with chronic bronchitis requires that greater attention be paid to patients’ subjective experiences of the disease.

Introduction

Chronic bronchitis, a disease which is prevalent in developing and industrialized countries, most frequently affects individuals aged >70 years who come from low-income backgrounds, are poorly educated and have histories of smoking and childhood respiratory illnesses; other risk factors include occupational exposure, particularly to dust and pollution (especially sulphur dioxide). The term ‘chronic bronchitis’ appears to have been introduced into the UK in the early nineteenth century to describe bronchial inflammation. Currently, the consensus definition of this disease is ‘the daily production of sputum for at least three consecutive months in two consecutive years’. Chronic bronchitis is a common cause of morbidity and mortality, causing 5% of deaths in the UK annually. During the 1960s as many as 17% of European men were affected and it has recently been estimated that approximately 25% of middle-aged adults in the USA are sufferers.

A acute exacerbations of chronic bronchitis (AECB) account for approximately 14 million visits to general practitioners (GPs) annually in the USA and are among the most common illnesses seen by them. These exacerbations are difficult to treat and prevention of both the disease and its progression lies principally in controlling smoking.
behaviour and implementing vaccination strategies. Chronic bronchitis is included in the generic term ‘chronic obstructive pulmonary disease’ (COPD) which also embraces other diseases of the lung such as asthma. Patients with COPD tend to have multiple pathologies.

E stimating the impact on the patient: quality-of-life measures

Patients spend virtually every day of their lives coping with the manifestations of chronic bronchitis and its effects on their well-being and social functioning. Chronic bronchitis is a disabling condition. Sufferers experience breathing difficulties which limit their physical activities and, depending on the severity of the disease, daily activities such as walking and climbing stairs may, at times, be extremely difficult. As a consequence, either consciously or unconsciously, patients reduce the amounts of routine physical activity they are willing to undertake, causing their levels of fitness to go into a downward spiral. There is also the potential for immobility to lead to medium- to long-term mental health problems, particularly loneliness and depression (although the prevalence of depression in COPD patients may be overestimated). Finally, there is evidence of co-morbidity, including musculoskeletal and cardiac problems.

The potentially frightening and often unpredictable nature of this disease, for example when patients are fighting for breath, may cause panic and stress which are likely to affect sufferers’ expectations of prospects for the future and to exacerbate fears related to morbidity. Patients are aware that there is no ‘cure’ for chronic bronchitis and their efforts are therefore concentrated on alleviation and access to treatment. As a result, medication, particularly inhalers and nebulizers, becomes part of everyday life.

Quality-of-life measures include factors such as physical and social functioning, limitations, pain, vitality, general health perceptions, impact of symptoms and mental health. In recent years there has been an increase in the number of studies of quality of life in patients with COPD. These demonstrated that the overall quality of life for those with advanced forms of the disease was approximately four times worse than that for patients with severe asthma when the two conditions were assessed according to similar criteria.

The treatment of patients with chronic bronchitis, and COPD in general, in common with other pulmonary diseases, has concentrated on alleviating symptoms. Most information concerning the outcome of treatment of patients with chronic bronchitis, however, has emphasized the importance of relieving physical symptoms and survival factors, as opposed to quality of life.

AECB are common and are usually diagnosed on the basis of increasing dyspnoea, sputum production and sputum purulence. Most exacerbations are precipitated by infection, although a large minority occurs following exposure to allergens, pollutants or inhaled irritants. They severely diminish lung capacity and this directly affects quality of life.

In recent years, increasing emphasis has been placed on patient-based evaluation of health and social care and this has led to a rapid growth in measures of quality of life. However, these variables are based on a health status model which focuses on objective measures and fails to take account of any subjective form of assessment. The concept of ‘quality of life’ is complex. Although there is clearly an overlap between an objective assessment of health status and individual perception, there is little doubt that a subjective assessment of health, which is influenced by factors such as personality, intellect, social and occupational status and personal history, is, on the one hand, relatively uncharted territory for health researchers and, on the other, of key importance to the individual’s perception of quality of life. As a result, there are currently very few subjective data on quality of life from the perspective of chronic bronchitis sufferers.

In the present study, qualitative subjective data obtained from focus groups of patients with chronic bronchitis were used to identify and evaluate the ways in which acute exacerbations of this disease affect sufferers’ perceptions of quality of life.

Materials and methods

Recruitment of participants

Subjects were recruited into the study if they fulfilled the following criteria: a diagnosis of chronic bronchitis (confirmed by a medical practitioner); as far as possible, the absence of other lung diseases such as asthma, emphysema and fixed airflow obstruction; and living predominantly in the community, i.e. without spending prolonged periods in hospital for reasons related to their underlying disease. An attempt was made to recruit five or six subjects from a broad range of age groups (including those below the age of retirement) and social classes and from both sexes into four focus groups. The subjects were drawn from the lists of three GPs in two industrial cities. The GPs were asked to identify patients who fitted the inclusion criteria and who were likely to agree to participate in group discussions of the type employed in the study. A study of the subject was not undertaken for the purpose of examining relationships between patient characteristics and behaviour, no demographic data, other than those relevant to the inclusion criteria described above, were collected. Consent to participate in the study was obtained from each subject.

Methodology

Subjects’ perceptions were obtained in group discussion sessions. Relevant topics were identified beforehand and
each group focused its discussion on the various topics in such a way that participants were able freely to express their views and convey their experiences. The investigators, as discussion leaders, ensured that all of the topics were covered and that the participants had the opportunity to say whatever they wished.

The topics were initially generated independently by each group leader, based on a knowledge of the scientific literature relating to quality-of-life issues specific to this patient population. They were discussed and refined into a first draft of the Focus Group Guide (FGG). This was then evaluated by the medical practitioner who identified the inclusion criteria, another psychologist, a health economist and a chest physician, none of whom were otherwise involved in the study. In addition, views regarding the relevance of the topics were sought from two chronic bronchitis sufferers who were also not involved. Once all of the comments had been received, the final version of the FGG was developed (Table).

### Data analysis

Data were analysed thematically, thematic analysis involving a procedure whereby the group transcripts were read to identify and categorize responses which emerged strongly, but independently, of the overt focus and which were underlying or separate from the pre-selected themes.

The transcripts of the discussions of the four groups were read by each of the investigators and, following discussion of the themes identified, a consensus regarding the broad thematic topics was reached. An external reviewer was also invited to identify broad themes from the transcripts. Those themes common to both investigators and the external reviewer were used for the data analysis; subthemes were identified by the same process.

### Results

#### Subjects

Of the 30 patients initially identified by the GPs, 22 agreed to participate. However, one individual in each of two

#### Table. Topics addressed by the discussion groups and comprising the Focus Group Guide

<table>
<thead>
<tr>
<th>Topic</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical effects</td>
</tr>
<tr>
<td>1.1</td>
<td>What factors most influence your sense of physical well-being?</td>
</tr>
<tr>
<td>1.2</td>
<td>What upsets you most at present about your physical condition?</td>
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<tr>
<td>1.3</td>
<td>How helpful is your current medication?</td>
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<tr>
<td>1.4</td>
<td>How far do you believe your condition can be treated/cured?</td>
</tr>
<tr>
<td>1.5</td>
<td>How do exacerbations affect you?</td>
</tr>
<tr>
<td>1.6</td>
<td>How serious is your condition in relation to others of which you know?</td>
</tr>
<tr>
<td>2</td>
<td>Social and emotional support</td>
</tr>
<tr>
<td>2.1</td>
<td>Do you live alone or with other members of your family?</td>
</tr>
<tr>
<td>2.2</td>
<td>How much do you rely on people close to you to provide you with practical support?</td>
</tr>
<tr>
<td>2.3</td>
<td>To whom do you turn for emotional support?</td>
</tr>
<tr>
<td>3</td>
<td>Relationships</td>
</tr>
<tr>
<td>3.1</td>
<td>How has your condition affected your close personal relationships?</td>
</tr>
<tr>
<td>3.2</td>
<td>Do you feel able to contribute as much to emotional/social relationships as you did before the condition developed?</td>
</tr>
<tr>
<td>4</td>
<td>Psychological health issues</td>
</tr>
<tr>
<td>4.1</td>
<td>Do you feel you are ‘the same person’ you used to be?</td>
</tr>
<tr>
<td>4.2</td>
<td>What are the factors in your everyday life that most influence how you feel?</td>
</tr>
<tr>
<td>5</td>
<td>Experience of the health services</td>
</tr>
<tr>
<td>5.1</td>
<td>How effective was your early treatment and diagnosis?</td>
</tr>
<tr>
<td>5.2</td>
<td>Were/are you satisfied with the level of care that was/is being offered?</td>
</tr>
<tr>
<td>5.3</td>
<td>How would you see the ideal kind of healthcare?</td>
</tr>
<tr>
<td>5.4</td>
<td>Are the healthcare services better or worse than you would have imagined?</td>
</tr>
<tr>
<td>6</td>
<td>Financial implications</td>
</tr>
<tr>
<td>6.1</td>
<td>Did you have to leave employment because of your condition?</td>
</tr>
<tr>
<td>6.2</td>
<td>Do you or your family draw any sickness benefit because of your condition?</td>
</tr>
<tr>
<td>6.3</td>
<td>What are your main financial concerns at the moment?</td>
</tr>
<tr>
<td>6.4</td>
<td>Are any of the health/social services offering advice/support on financial matters?</td>
</tr>
<tr>
<td>6.5</td>
<td>Is your accommodation adequate?</td>
</tr>
</tbody>
</table>
groups failed to attend the discussions. Therefore, 20 subjects (10 males and 10 females) were recruited. Five were assigned to each of four focus groups, two in each city. The male:female ratios in the four groups were 3:2, 2:3, 1:4 and 4:1, respectively. The ages of the subjects ranged from 30 to 86 years, with the mean ages for the groups being 62.6, 66.2, 71.4 and 58.8 years, respectively.

Thematic analysis

The observations of the investigators are supported by extracts from the transcripts. Three main themes that dominated each of the four discussions during which the patients’ perceptions of quality of life were explored were identified: (i) the physical effects of the disease and dependency on medication; (ii) the impact of the disease on family and social relationships; and (iii) emotional reactions, life disruption and self-esteem. These will not be considered in detail here. Rather, the emphasis will be on subthemes relating to AECB and smoking behaviour.

The data confirm that AECB have had profound adverse effects on the participants’ already poor quality of life. Included among the emotions expressed were panic and dread, dependence on oxygen, reduced self-esteem, loss of control over physical health, fear of public encounters arising from embarrassment about symptoms, and perceptions that GPs were not always as helpful as they might be. In addition, there was evidence that subjects’ knowledge, beliefs and behaviour associated with giving up smoking were not invariably realistic. These subthemes are considered in detail below.

1. AECB were common among the participants; their onset was met with both panic and fear. One participant described the feelings on experiencing the first ‘attack’:

   Well, this all started off with a bad cold and I found out on the Wednesday when I went to see the doctor because I was struggling to breathe. I just thought it was a chesty cold. A nd she said, ‘Ring me on the Friday, to let me know,’ because she put me on a nebulizer in the surgery and then she gave me these tablets. ‘Ring me in the morning to let us know if you are any better.’ Well, I was trying to ring her on the phone but I couldn’t breathe. It was like trying to breathe through a pinhole. That’s just what it was like trying to get my breath. A nyway, the nurse came up from the surgery because they had dialled the number to find the number [from which she had telephoned] and they whipped me straight into hospital on the Saturday. I didn’t even know I was in the hospital. They had taken me in Friday night and I didn’t even know while [local dialect for ‘until’] Monday that I was in hospital. I was out. Gone! A nd that’s when my trouble started. That was 2 years ago. Since then it’s gotten worse and worse and worse so I can’t walk up the street now. [FGG Topic 1]

   A nother subject described the anxiety and panic from coughing during an infective episode thus:

   I haven’t had it, touch wood, for—a bad one anyway—for 6 months. I only cough three times a day. But it’s one of them right whoopers—when your eyes are watering and you feel as though it’s stuck in your windpipe. That’s when you panic—you think you’re not going to be able to breathe. That second to me feels like an hour. [FGG Topic 1]

   Y et another subject’s experiences were described as follows:

   Subject: Well, I’m inclined to panic, because the more I cough, the more breathless I get, and I just get myself so I just can’t get a breath.
   PN: So what do you do then? When you say you’re coughing, you panic. Then what do you do?
   Subject: I just try to refrain from coughing, stop coughing, although I can’t. The more I cough, the more breathless I get. I panic. [FGG Topic 4]

   Subjects were able to predict the onset of exacerbations after the first few episodes and this had the effect of increasing their dread:

   I know sometimes when it’s coming on because my chest starts to burn. I know it’s coming on within the next day. I can get air into my lungs but it seems I can’t get any oxygen out of the air. It’s like breathing bad air—it’s terrible. I can’t get any oxygen out of the air. [FGG Topic 2]

2. The predominant coping strategy was to ensure that medication was carried at all times. There was a clear issue of dependency on the medication which was both physical:

   If I get a cold, within a very short time I get a severe infection on me chest and have to take steroids. [FGG Topic 1]

   and psychological:

   I couldn’t cope without them. I start to panic when I realize I’m getting low on them. [FGG Topic 1]

3. The participants were unwilling to appear in public, particularly when they had colds or were experiencing exacerbations. Some found certain features of their disease distasteful and embarrassing. Often they needed someone to be there to help them, a situation which increased their embarrassment. For example:

   Then, if you do partial drainage to get rid of phlegm, you know, if you lean over the couch for hours with your head on the ground and somebody puts a pad on to your back.... [FGG Topic 3]

4. The effect of this embarrassment and the subsequent distress on subjects’ self-esteem overflowed into their sense
of motivation for a social life, typified by the following comment:

> Sometimes you get a wheeze, and when you start wheezing it’s terrible. People ask if you are alright. You say ‘yes’ to be polite. It don’t stop you coughing. It still has to have that run before it stops. [FGG Topic 4]

Over the medium to long term, anticipation of the onset of symptoms reduced subjects’ expectations of what was possible in their lives. This led to avoidance of a social life for many and not taking holidays abroad because of temperature extremes and atmospheres that exacerbate their underlying condition. One participant stated, ‘The weather matters a lot. I prefer cold weather to hot weather. That is really a worry’. However, this was not the view of everyone. One person noted that ‘In really cold weather I’m in trouble’, while another commented, ‘I can’t have a bath ‘cause I get out of breath.’ Yet another described one particularly severe episode as follows:

> One day I collapsed and finished in hospital ‘cause, what I did, I got out of the bath and I have one of those spray things for the bath, to rinse off before I get dried. The fumes from it knocked me out flat. I just stumbled into the bedroom and was down and out. Done! [FGG Topic 1]

5. There was a general impression that, although GPs try to be helpful, they tend to avoid prescribing antibiotics, a practice that is at variance with the widely held, albeit incorrect, view that these drugs are beneficial in terms of alleviating symptoms. This failure to comply with their expectations annoyed many of the participants who were reluctant to accept GPs’ explanations regarding the treatment of their exacerbations. The consensus was that doctors do not appreciate the severity of their patients’ discomfort. A subject said, ‘it’s gone off by the time the doctor comes to see you.’ A mother was angry because the GP had said ‘There’s nothing on your chest. There’s a wee bit of tightness, but antibiotics are no help.’ Yet another said:

> They can’t appreciate what you’re feeling so you are wasting your time talking. They are sympathetic but they don’t really understand. They don’t know the pain and suffering that you go through sometimes—’cause there is a lot of pain with it, especially around the lungs and chest. [FGG Topic 1]

However, this does not prevent patients from going to their GPs, simply because they feel the need to do something and they do not know what else to do:

> PN: So how do you make this decision, whether to go to the doctor, whether to call the doctor out?
> Subject 1: Y ou just go tight, and you cannot move, so you know yourself you’re due antibiotics for something.

Subject 2: Y ou bring up phlegm and look at it?

PN: Do you bring up phlegm and look at it?

Subject 2: Oh aye, but I mean, I’m in this place [health centre] every day nearly. But you can tell, you know? I mean, you’ve got your coloured charts. You know whether it’s black, green, blue or what! [FGG Topic 4]

AECB, then, lead to acute psychological/emotional distress which appears to intensify the impact on quality of life in this patient group. A n acute exacerbation increases loss of self-esteem and creates issues relating to medication which add to the general impact chronic bronchitis has on patients.

6. Knowledge, belief and behaviour do not always correspond. Subjects who talked about the onset of their illness attributed its causation to smoking, although this recognition did not necessarily influence their behaviour. The association between smoking and chronic bronchitis is not only widely documented in the scientific literature, it is also actively promoted by GPs to their patients. Subjects in this study were well aware of the negative impact of smoking on their health, but found it difficult to relate their knowledge to their behaviour.

PN: Do you smoke?

Female subject: I do, but I wish I didn’t. It’s terrible, terrible. I’ve been born with bronchitis. My father had it and I’ve had it all my life. [FGG Topic 3]

A Is:  

Subject 1: The craving always gets to you.

Subject 2: We’d all like to stop, but I think, once you’re addicted . . . . I lost my husband 3 years ago and it’s worse because I miss him terribly. It’s worse, you know. That’s why I smoke, because I miss him terribly. [FGG Topic 3]

Not all of the participants believed that smokers should be held responsible for their own health or that smoking had a negative impact:

Subject 1: I blame myself for smoking all my days. I mean, it’s my own fault. I know. I fully appreciate that.

PN: Do you blame yourself?

Subject 2: Oh yes. I certainly do. I certainly do.

Subject 3: I don’t know why we can blame ourselves, because we smoke. A fright, they keep saying . . . . I mean, people who went down the pits . . . . My father had it [lung disease] and died from it and never had a cigarette or drink in his life. My two brothers and all, they never drank or anything. But we can’t blame . . . . I blame the environment. [FGG Topic 4]

There was avowed ambivalence about smoking among the participants. It appeared that the smokers and ex-smokers were trying simultaneously both to accept responsibility.
and to avoid acknowledging the dangers of smoking. In the following extract a young woman who continues to smoke is criticized by an older one. The former accepts this criticism without commenting. Her mother suffers with COPD and is severely disabled and she takes this as a warning, although without changing her behaviour.

Subject 1: I know it isn’t [good for me]. I have cut down. I used to smoke 20. I have started buying 10 packets, and like me partner keeps saying to me, ‘You will end up like your mum.’ He don’t smoke and I work in a hospital. [Her husband says,] ‘How can you smoke when you work in a hospital? I don’t smoke. It should be easier for you to pack in.’ But I’ve been smoking since I was 10 year old and I’m 30 now.

Subject 2: What you want is a good sharp rebuking. [FGG Topic 2]

In another case, the same conflict of behaviour, belief and knowledge is also apparent:

I’d love to stop. I mean, I only have the five a day, which is too much, but they’re extra mild. But it’s a filthy habit. We know that. But you see, with me, it was boredom, because my boys were getting up and going to dance, and I was left in the house by myself, and I was really bored. And then, when somebody came in and said, ‘Try a cigarette’ . . . . and then I tried a drink. [FGG Topic 4]

This woman, in common with some of the others quoted above, recognized the dangers of the ‘filthy habit’ but justified smoking on the grounds that the cigarettes were ‘mild’. She also blamed someone else for starting her on the habit during a period in her life when she was unhappy. She characterized this as a ‘fall from grace’ in that she started smoking at the same time that someone suggested that she start to ‘drink’ as well.

Most participants had been smokers at some time in the past. Those who no longer smoked were slow to give up and often did so only because they could not smoke, rather than because they knew it was damaging to their health. This was either because of expense:

Yes, I started smoking about when I was 18 and I stopped at 46 and I only stopped smoking because they were starting to go up in price and I said if they go up this time I’m not smoking no more. [FGG Topic 2]

or because cigarettes directly caused very unpleasant effects:

I find smoking sometimes brings up a lot of phlegm. [FGG Topic 3]

It seemed, overall, that it is possible to stop smoking, but only when something precipitated a sharp realization of the damage to personal health:

I used to smoke nearly 40 a day and have 10 pints a night and I tell you, when I walked up this hill on Sunday morning going to the White Hart, I had to turn back after 40 yards. She [his wife] said, ‘What’s up?’ ‘I can’t get me breath.’ She said ‘Sit down.’ I tell you, when I went next day to the doctor and he sent me to the [local hospital] for X-rays and all that . . . . ‘If you don’t stop smoking and drinking you will be dead.’ Sharp thing! I never had one after that. [FGG Topic 2]

Smoking was regarded by some as a symbol of potency and adulthood:

Male subject: Well, it [number of cigarettes] gradually went up and up. I daren’t have smoked in the house. My father would have rammed them down me throat, but me brother had people coming from different parts of the country and one of them says to me dad—he come from Stoke—‘Can I give him a cigarette,’ Mr L., being as they are in company? ‘You can do.’ And when I look back, that were worst day of my life.

PN: B because you didn’t stop after that?

Male subject: I didn’t stop after that. It just went up and up and I used to smoke 40 a day. I were about 20 or 30. Capstan full strength and then I went on to Senior Service.

PN: Did you enjoy smoking?

Male subject: Y es. Oh, aye! [FGG Topic 2]

Despite subjects’ knowledge (at an intellectual level) and beliefs, smoking is a habit which provides a high degree of benefit to the smoker. It is a comforting and soothing activity, as well as one that is enjoyable at a social level. Health and pleasure were seen by subjects as being in direct contrast. Even those who had been shocked into stopping expressed regret at losing that pleasure.

Discussion

An unresolved issue among focus group experts is whether a homogeneous or heterogeneous composition is more effective in terms of eliciting useful data. In this study, the latter was sought on the basis that it was more likely to stimulate discussion and to provide the widest possible insight.

It is generally agreed that the optimal number of subjects necessary to ensure effective and meaningful discussion is between six and eight per group. Too few subjects may lead to early agreement and, thus, a premature end to the discussion, while too many discourages participants from contributing and creates difficulties with transcribing, thereby reducing the amount of data collected. Moreover, it is the principal investigator’s experience that a group of mainly working class subjects with no previous experience of discussing their illnesses with strangers in a formal setting would feel most secure and would be most likely to participate in smaller groups in which they would not be
competing for ‘talking time’. For these reasons, the recruitment target was five or six participants per group.

The participants were drawn from industrial, working-class cities. They came, almost exclusively, from lower socio-economic backgrounds and most had experienced limited opportunities in life. They had worked in heavy industry or in smoke-filled environments and they came from families with histories of ill health, including COPD. A few but one had smoked at some time and several persisted with this habit, despite strong medical advice to the contrary. This profile is similar to that of the ‘typical’ patient with COPD. None the less, the disease and the limitations imposed by it changed the ways in which subjects lived their lives and their expectations of future opportunities. There were several dimensions to this experience.

Underlying the participants’ experiences of a chronic illness were senses of loss and psychological disruption. These feelings manifested themselves at a number of levels. Much of each subject’s day-to-day behaviour was focused around the loss of good health, which included coping with the limitations imposed by his/her disease and administering medication. The disease also led to a loss of autonomy, with subjects becoming increasingly dependent on their friends and relatives. Furthermore, they had lost the ability and, sometimes, the desire to lead fully active domestic and social lives. A significant factor contributing to this was the loss of control over their health and lives, owing to the unpredictability of the onset of exacerbations and not knowing how they would cope with the demands they faced each day.

The accumulation of all of these losses typically leads to a sense of disruption, both of continuity and integration of identity. This disruption is incompatible with an individual sense of well-being and control over one’s destiny and may, in the extreme, lead to psychological disturbances. It would certainly be capable of promoting anxiety (manifested in relation to medication, fear of not receiving the best medical advice or treatment, the dread of exacerbations and atmospheric pollution) and depression. This may have been reflected in the ‘fatalism’ expressed by the participants about their health. None the less, it was surprising to note the extent to which the inability or lack of desire to cease smoking persisted, despite anecdotal evidence, advice from GPs and the constant barrage of warnings to the contrary in the media. Some individuals attempted to justify continuing to smoke and those who had succeeded in stopping seemed to do so only after experiencing severe health ‘scars’, in conjunction with direct medical advice. Warnings from relatives, friends and, in this case, even other group members were not always sufficient to persuade them.

The results of the present study were based on the subjective perceptions of a small sample of chronic bronchitis patients. However, the data here clearly resonate with those from research on quality of life and complement such studies with detailed descriptions. Research into the quality of life of patients with COPD has generally employed objective measures. The full complexity of the psychological dimensions of this disease, however, would be difficult to assess on the basis of objective measures alone. The results of this study, in which participants were encouraged to express the depths and complexities of their subjective experiences in the context of attempts to account for their behaviour, have therefore added an important dimension to existing knowledge of this subject. Subjective experience is often apparently contradictory, in that an individual will make statements at different stages of an interview or focus group session which will appear to be at variance with assertions made previously. Qualitative research which encourages participants to convey their personal experiences allows complexities associated with the contradiction in human experience and its subjective meanings to be revealed and scrutinized. Group discussions provide additional opportunities for such contradictions to be tested and challenged by other participants. By focusing on participants’ experiences, research of this type gives investigators, healthcare professionals and patients’ relatives a degree of ‘access’ to the pain and everyday dilemmas experienced by sufferers of chronic bronchitis. It also offers insight into the manifold ways in which this group of patients has developed strategies enabling them to cope with their affliction.

Conclusions

Chronic bronchitis, in common with all COPD’s, is, on the one hand, a disease of high prevalence but, on the other, one that is ‘invisible’, in that it is often under-diagnosed. A major problem in the management of patients with chronic bronchitis (and COPD in general) is the contrast between the health benefits to sufferers arising from giving up smoking and the difficulties and, sometimes, lack of intention or willpower encountered in some patients in relation to this. Further research is needed in order to identify the most effective ways of delivering health warnings to persistent smokers.

The findings of this study complement and reinforce much of the existing knowledge of the quality of life of chronic bronchitis patients and add the important dimension of how patients subjectively identify, cope with and make sense of their own experiences, in particular the extent to which exacerbations bring about medium- and long-term emotional distress.

AECB exert a major impact on sufferers’ quality of life which is already poor. They must endure not only the physical symptoms per se, but also a lack of control over their day-to-day behaviour arising from the unpredictability and severe debilitating effects of exacerbations which further erode their abilities to function socially.

In the absence of a cure for chronic bronchitis it is clearly important that quality-of-life researchers identify issues.
which influence the ability to perform everyday activities, the psychological effects of the disease and the resulting impairment of functioning on patients’ lives. The present study has uncovered some of the prosaic subjective experiences associated with being a sufferer of this disease, including the embarrassment and fear and anxiety provoked by the expectation of an exacerbation, and the need for greater efforts to target the persistent smoker. It has also revealed that, for some sufferers, there is a perception of unmet primary healthcare and emotional needs. These needs could be met by specialist counselling and nursing services which would provide clinical information and psychological support during acute exacerbations and which would also address related issues, such as rehabilitation, health-related behaviour, giving up smoking, physiotherapy and exercise.

Acknowledgement

We acknowledge the support of Glaxo Wellcome Research and Development to this study.

References