

# “Somebody to Say ‘Come On We Can Sort This’”: A Qualitative Study of Primary Care Consultation Among Older Adults With Symptomatic Foot Osteoarthritis

MARTIN J. THOMAS, ANDREW MOORE, EDWARD RODDY, AND GEORGE PEAT

**Objective.** To examine the experiences of primary care consultation among older adults with symptomatic foot osteoarthritis (OA).

**Methods.** Eleven participants (6 women and 5 men) ages 56–80 years who had radiographically confirmed symptomatic foot OA and consulted a general practitioner in the last 12 months for foot pain were purposively sampled. Semistructured interviews explored the nature of the foot problem, help-seeking behaviors, and consultation experiences. Verbatim transcripts were analyzed using interpretative phenomenological analysis.

**Results.** The decision to consult a physician was often the outcome of a complex process influenced by quantitative and qualitative changes in symptoms, difficulty maintaining day-to-day roles and responsibilities and the effect this had on family and work colleagues, and a reluctance to present a fragile or aging self to the outside world. Self-management was commonly negotiated alongside multimorbidities. Upon seeking help, participants often believed they received limited information, they were given a brief or even cursory assessment, and that treatment was focused on the prescription of analgesic drugs.

**Conclusion.** This is the first qualitative study of primary care experiences among patients with symptomatic foot OA. The experience of primary care seldom appeared to move beyond a label of arthritis and an unwelcome emphasis on pharmacologic treatment.

## Introduction

Foot pain and disorders independently contribute to mobility impairment (1). While the circumstances that lead

people to consult physicians for foot problems and broader health concerns are complex (2–4), among doctors, vague and less visible chronic conditions of the lower body, such as foot osteoarthritis (OA), often lack prestige, particularly in elderly patients (5). This is reflected in the lack of clear clinical guidance on how to assess and manage symptomatic foot OA. In primary care services, where most musculoskeletal health care is provided (6), effective foot care remains hindered by a limited understanding of which clinical manifestations and consequences should be the focus of patient-centered management strategies. Through the examination of health contact from the patients' perspectives, this study aimed to investigate primary care consultation experiences in older adults with symptomatic foot OA.

## Patients and methods

Semistructured interviews were conducted by a trained researcher (MJT) in a purposive sample of 11 participants

Supported by Arthritis Research UK (grant 18174). Mr. Thomas' work was supported by the West Midlands Strategic Health Authority through a Nursing, Midwifery, and Allied Health Professionals Doctoral Research Training Fellowship (NMAHP/RTF/10/02).

Martin J. Thomas, BSc (Hons), MSc, Andrew Moore, BSc (Hons), PhD, Edward Roddy, DM, FRCP, George Peat, BSc, MSc, PhD: Arthritis Research UK Primary Care Centre, Research Institute for Primary Care & Health Sciences, Keele University, Staffordshire, UK.

Address correspondence to Martin J. Thomas, BSc (Hons), MSc, Arthritis Research UK Primary Care Centre, Research Institute for Primary Care & Health Sciences, Keele University, Keele, Staffordshire, UK, ST5 5BG. E-mail: m.thomas@keele.ac.uk.

Submitted for publication December 20, 2012; accepted in revised form June 21, 2013.

## Significance & Innovations

- This is the first qualitative study of primary care experiences among patients with symptomatic foot osteoarthritis (OA).
- Recognizing and prioritizing symptomatic foot OA alongside other health concerns is a challenge for both patients and general practitioners.
- Patients described a primary care service that seldom appeared to move beyond a label of arthritis and an unwelcome emphasis on pharmacologic treatment.
- As a prerequisite to enhance consultation experiences, the evidence base for diagnosis and management of foot OA in primary care needs strengthening.

(6 women and 5 men ages 56–80 years) registered with 3 general practices in North Staffordshire who took part in the Clinical Assessment Study of the Foot (CASF), a population-based cohort study (7). Participants were eligible if they had symptomatic foot OA and reported in their baseline health survey questionnaire that they had consulted a general practitioner (GP) within the last 12 months for foot pain. Symptomatic foot OA was defined as having foot pain in the preceding 4 weeks, shaded on a foot manikin (copyright the University of Manchester, 2000. All rights reserved) (8), and having radiographic foot OA. Dorsoplantar and lateral foot radiographs were taken according to a standardized protocol (7) and scored for OA by a single reader using a foot atlas (9). Radiographic foot OA in this analysis was defined as a score of  $\geq 2$  for osteophytes or joint space narrowing on either view in at least one of the first or second cuneometatarsal, navicular first cuneiform, or talonavicular joints (9).

Interviews were undertaken using a topic guide structured around key questions and possible prompts concerning the nature of the problem in the context of the individuals' broader health, the decision to seek help for the foot problem and the pattern of help seeking, and their health care experiences. The topic guide was developed and refined during 4 prestudy pilot interviews and is available upon request from the corresponding author. The interviews were conducted in the participants' homes and lasted between 30 and 59 minutes.

Ethical approval for this study was obtained from the Staffordshire Research Ethics Committee (REC reference: 11/WM/0079). All participants provided written informed consent to participate.

For data analysis, the interviews were audio recorded, transcribed verbatim into written format, and anonymized with pseudonyms. The transcripts were analyzed using an interpretative phenomenological analysis, broadly set within the framework detailed by Smith et al (10). Each transcript was formatted into a Microsoft Word document and inserted into the central column of a 3-column table. The interview text was then read and reread, and notes were made against important and relevant sections of text

in the right-hand column. A second cycle of analysis was used to determine the initial themes being formed from these notes, which were annotated into the left-hand column. Individual themes identified as having shared connections were clustered into superordinate themes before being entered into a summary table for each participant. Each transcript was analyzed in its entirety before beginning the next. Moving across cases, new themes together with similarities that reinforce the extant theme were compared and evaluated against previous transcripts, and thus the process was cyclical. This is not saturation, but allied to the utility of Heideggers's hermeneutic cycle by interpretative phenomenological analysis (10). Superordinate themes that emerged across transcripts were used to present the idiosyncrasies between cases within each theme. The data analysis was conducted by the first author (MJT, a physiotherapist with previous qualitative interviewing experience), with the second author (AM, an experienced qualitative social scientist) reviewing and auditing both the data collection process and theme generation to verify that their construction and development were rooted within the transcripts. Finally, a narrative account was generated with the participants' verbatim quotations integrated throughout to support the analysis. The overall themes presented were not based on prevalence but based on illustrative power and relevance to the topic.

## Results

Table 1 shows the distribution of participants across 3 primary care practices. Three main themes emerged from the analysis of interview transcripts: day-to-day impact and managing symptoms, searching for explanations, and consulting and meeting needs. Within each theme, a number of subthemes were constructed and supported with verbatim quotations.

**Day-to-day impact and managing symptoms.** On some level, for all participants, mobility was restricted or affected by foot pain. The significance and meaning of this is better understood in the context of disruption of everyday work and activities and the ability to present an able-bodied image:

“Being self-employed, I was getting to the point where I was working and I couldn't work, so I was losing . . . my self-respect

**Table 1. Characteristics of the interview participants**

Participant	Age, years	Sex	Practice
Emily	69	Woman	A
Hope	78	Woman	C
Janet	57	Woman	C
Julie	56	Woman	B
Mo	80	Woman	B
Polly	56	Woman	C
Bobby	62	Man	A
Ernie	59	Man	A
Joe	65	Man	C
John	76	Man	C
Stan	71	Man	C

as far as not been doing enough work every day right? . . . I wasn't doing my work 100%" (Bobby).

"It's had a terrific effect on the social side of things, because I was a very active person. I used to play racket ball, I used to swim, and I used to do PE [physical education] twice a week at work with the kids. It's had an impact on that side of it socially. Shopping's not an enjoyable experience because now after about half an hour I've had enough, I've got to get off my feet and because of the pokers [sharp pains], I've also got to get off the feet because my back is absolutely crippling me" (Julie).

While Bobby experienced a loss of self-respect as a worker, Julie believed foot pain impacted her ability to socialize and maintain her everyday responsibilities.

Among some of the women interviewed, footwear and appearance were important elements of a desirable self-image, particularly being young and able-bodied:

"I think about them all the time, because when I'm going out, I think 'do my bunions stick out, do my shoes look alright.' I'd love to wear strappy sandals and your flip flops and all that sort of thing, but I never would" (Emily).

"I've always maintained I want to be fashionable and everything. Even at my age I like to look nice and it's nice to wear nice things and nice shoes" (Janet).

These quotes illustrate that Emily and Janet shared similar experiences; while one person was self-conscious, the other enjoyed remaining fashionable. This suggests that conflicting feelings toward footwear may need to be managed in relation to pain, function, and a desirable or acceptable self-presentation. Although the importance of footwear selection did not emerge for men, for some men, foot pain still impacted their self-presentation: "I don't like limping . . . I think it don't look nice" (Stan).

Attempts to self-manage painful foot symptoms were often described in conjunction with other health concerns such as pain at other joint sites and comorbid conditions: "It's all connected" (Janet). "It's not continuous in one part, it's all over" (Bobby). These other health concerns may take precedence in terms of the decisions made to consult a GP. Altering daily activities with foot pain was often evaluated in terms of overall health concerns and lifestyle, as the following quote from Janet shows:

"Now what I've started to do on a good day I'll walk into [town] with my walking stick and then I'll get a taxi back. I'm doing that because I'm thinking of what my hearts . . . you know, trying even though it absolutely cripples me, I'm doing that now because I need the exercise" (Janet).

For some individuals, the complexities and idiosyncrasies of multimorbid presentations may be mirrored in the intricacies of their maintenance and management.

**Searching for explanations.** An increased frequency and intensity of abnormal symptoms motivated people to seek help:

"Because I got a pain underneath my foot and I didn't know what it was" (Polly).

"Because my feet were getting more painful and very, very sore" (Emily).

These quotes illustrate wanting an explanation for increasing pain. For John, it was more about gaining reassurance:

"When I did bring it up at the time, it was really painful and I was getting it regularly. And I thought whether I'd broke it . . . twisted it badly, or something" (John).

Participants predominately saw their GP, despite additional health care options being available (e.g., a physiotherapist or podiatrist/chiroprapist). When the participants were asked if they had seen any other health professionals, they provided insight into their level of knowledge about other sources of health care. While 4 participants consulted their GP specifically for foot pain, the majority mentioned foot pain when consulting their GP for other reasons.

"I think mainly I consult him because I have to see the doctor every 3 months anyway because of my diabetes" (Hope).

Although some participants understood a "need to see the GP for referral" (Ernie), others believed it was "pointless going to see anyone else" (John), having perceived the view of their GP to be final. Even upon direct questioning, the participants appeared unaware that physiotherapy may have a role in their treatment: "I didn't know that the physios did feet" (Stan). In terms of knowing whom to turn to, the different experiences and perspectives across cases included consulting a GP to obtain a referral, feeling resigned to authority following a consultation, and lacking in knowledge regarding the first point of care options.

**Consulting and meeting needs.** Although they consulted their GPs to enable better management of symptoms and their consequences, the participants often perceived being given limited information and brief assessments as not being taken seriously:

"I was disappointed that he just touched it and I can't see how he can tell it's what it is just by doing that to it" (John).

"He just examined it, moved it all different ways and that was what he come up with, he says 'you've got arthritis'" (Polly).

A lack of visual change in appearance, the perceived brevity of the GP's assessment, and the lack of postexamination advice left some participants feeling at times that their concerns were invalid:

"I might as well have just talked to me mates down the pub" (Ernie).

There also appeared to be a predominant emphasis on symptom management with analgesics, which was unwelcome:

“. . . [Doctors] keep chucking the pills at you” (Bobby).

“They just say ‘well, it’s just arthritis and old age,’ and just keep on popping the pills” (Hope).

This frustration was epitomized by Stan when he stated that all he wanted was “somebody to say ‘come on we can sort this’” (Stan).

The participants perceived that there was a lack of advice given to them, other than that on medication use, because they did not generally discuss any other aspects of intervention or treatment. In terms of not having their needs or expectations met by the GP, some participants framed their concerns relative to other peoples’ health problems. Three participants evaluated their foot pain against health issues they believed were more important based on their impact and consequences:

“What makes me better really is I mix and talk to people of my own age. . . . And they’re [friends] a lot worse off than I am” (John).

“There’s worse people off with worse conditions, you know, yours is trivial compared to people who have got worse illnesses, but at the time, you just want to be normal and have normal shoes and not have this throbbing and everything” (Janet).

Such comparisons appeared to facilitate regaining some sense of control following the despondency experienced after a negative consultation experience. For these individuals, the lack of treatment or GP intervention appeared to undermine the status of the foot symptom, framing it as less significant compared to more serious conditions such as cancer in terms of overall morbidity and mortality.

Although the majority of participants described negative consultation experiences, 5 participants talked about reconsulting their GP in the future. A fear of deterioration, hope for the advent of new ideas and treatment, and lack of perceived options other than the GP for intervention emerged as triggers to reconsultation:

“If it did get worse, I would go to the doctors now. Because I wouldn’t want it to progress any further if possible” (Stan).

“At the moment, it’s manageable, only if it got any worse whereby it restricted my movements to the degree that I couldn’t go out or couldn’t walk or drive, I would obviously get some—well, seek further advice” (Joe).

## Discussion

While the personal consequences of symptomatic foot OA often mirror those expressed by people who have hip or knee OA (11,12), we found aspects that were particular to the foot. Being perceived as able-bodied appeared to have important implications for how participants view and

present themselves and their everyday foot-related impairment. For some women, footwear in particular and appearance contributed to the perception of being able-bodied. The participants’ experiences indicated that although consulting a doctor formed part of the remedy for the painful consequences, the low priority and lack of clear assessment of foot pain provided further challenges to consultation. In some cases, foot pain was afforded less attention by both the patient and GP when also consulting for other health problems deemed to be more important. Conversely, some consultations for other comorbidities provided opportunities to raise the foot problem with the doctor without planning a separate visit. There also may have been synergies for management, for example, exercise prescription for joint pain and comorbid cardiovascular conditions.

The complexity of the foot pain consultation experience appeared to be exacerbated by the extent to which people may have been actually talking about symptomatic foot OA. For several participants, their foot problems had little distinct or discernible identity of their own; the foot problems were simply part of their arthritis. Although the focus of the interviews was always brought back to the foot, it is clear that some participants struggled to disentangle symptomatic foot OA from more general OA.

Referral to other health professionals did not appear to be common, and some patients believed their GP had failed to undertake a skilled assessment or did not provide information beyond a label of arthritis and the promotion of analgesics. Evidence also suggests that some GPs may lack confidence and training in the examination of foot problems (13), and in primary care, greater use of other disciplines (e.g., physiotherapy and podiatry) may be indicated to optimize the use of time and resources (14). This specific area requires future research.

The purposive selection of participants from a population sample frame ensured the accurate identification of cases matching a symptomatic foot OA phenotype. However, the predominantly negative consultation experiences of the sample could in part reflect the recruitment of symptomatic individuals. Those dissatisfied with primary care services or those still searching for explanations and treatment may have been more likely to take part in CASF and accept the interview invitation. These interviews also represent only one perspective of the consultation experience and the concurrent views of GPs remain unknown. This represents another area requiring further research.

In conclusion, this is the first qualitative study of primary care experiences among patients with symptomatic foot OA. Our findings on the experience of consultation largely parallel those from previous studies of hip or knee OA and minor ailments. More site-specific issues included the importance of footwear and foot appearance, especially for some women, and the difficulty for patients and GPs to recognize and prioritize foot symptoms alongside other problems. A challenge for health care professionals implicit in our findings is how to move beyond a label of arthritis and an unwelcome emphasis on pharmacologic treatment. To do this, the evidence base for the diagnosis and management of foot OA in primary care needs strengthening.



## ACKNOWLEDGMENTS

The authors would like to thank Charlotte Purcell for administrative support and Dr. Michelle Marshall for scoring the radiographs. We would also like to thank Adam Garrow and the University of Manchester for permission to use the foot manikin (copyright the University of Manchester, 2000. All rights reserved).

## AUTHOR CONTRIBUTIONS

All authors were involved in drafting the article or revising it critically for important intellectual content, and all authors approved the final version to be published. Mr. Thomas had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Study conception and design.** Thomas, Moore, Roddy, Peat.

**Acquisition of data.** Thomas.

**Analysis and interpretation of data.** Thomas, Moore, Roddy, Peat.

## REFERENCES

1. Menz HB, Lord SR. The contribution of foot problems to mobility impairment and falls in community-dwelling older people. *J Am Geriatr Soc* 2001;49:1651–6.
2. Menz HB, Jordan KP, Roddy E, Croft PR. Musculoskeletal foot problems in primary care: what influences older people to consult? *Rheumatology (Oxford)* 2010;49:2109–16.
3. Uhlig T, Hagen KB, Kvien TK. Why do patients with chronic musculoskeletal disorders consult their primary care physicians? *Curr Opin Rheumatol* 2002;14:104–8.
4. Campbell SM, Roland MO. Why do people consult the doctor? *Fam Pract* 1996;13:75–83.
5. Album D, Westin S. Do diseases have a prestige hierarchy? A survey among physicians and medical students. *Soc Sci Med* 2008;66:182–8.
6. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and Health. *Milbank Q* 2005;83:457–502.
7. Roddy E, Myers M, Thomas MJ, Marshall M, D’Cruz D, Menz HB, et al. The Clinical Assessment Study of the Foot (CASF): study protocol for a prospective observational study of foot pain and foot osteoarthritis in the general population. *J Foot Ankle Res* 2011;4:22.
8. Garrow AP, Silman AJ, Macfarlane GJ. The Cheshire Foot Pain and Disability Survey: a population survey assessing prevalence and associations. *Pain* 2004;110:378–84.
9. Menz HB, Munteanu SE, Landorf KB, Zammit GV, Cicuttini FM. Radiographic classification of osteoarthritis in commonly affected joints of the foot. *Osteoarthritis Cartilage* 2007;15:1333–8.
10. Smith JA, Fowler P, Larkin M. Interpretative phenomenological analysis: theory, method and research. London: Sage; 2009.
11. Hawker GA, Stewart L, French MR, Cibere J, Jordan JM, March L, et al. Understanding the pain experience in hip and knee osteoarthritis: an OARSI/OMERACT initiative. *Osteoarthritis Cartilage* 2008;16:415–22.
12. Sanders C, Donovan J, Dieppe P. The significance and consequences of having painful and disabled joints in older age: co-existing accounts of normal and disrupted biographies. *Sociol Health Illness* 2002;24:227–53.
13. Gorter K, de Poel S, de Melker R, Kuyvenhoven M. Variation in diagnosis and management of common foot problems by GPs. *Fam Pract* 2001;18:569–73.
14. Foster NE, Hartvigsen J, Croft PR. Taking responsibility for the early assessment and treatment of patients with musculoskeletal pain: a review and critical analysis. *Arthritis Res Ther* 2012;14:1.