CONVALESCENCE AND CHRONIC ILLNESS

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ERNST P. BOAS, MD

A few years ago there would have been no place on a program such as this for a discussion of the relationship between chronic illness and convalescence. Convalescence was regarded strictly as "the period between a patient's acute illness and his return to his previous state of health," a definition which still stands as the accepted one in the Minimum Standards for Convalescent Homes. Convalescent care was provided for persons recovering from acute infectious disease such as pneumonia or typhoid fever, or from the effects of operative procedures provided their wounds were healed. Patients were selected in whom one might expect complete cure and rehabilitation.

The experience of convalescent homes during the past decade or so has demonstrated that such a narrow definition circumscribes the scope of convalescent care. Actually convalescent homes are caring for a wider variety of types of patients, although they reject as unsuitable many who clamor for admission. It is not the patients alone, but medical social workers and physicians, too, who are constantly striving to extend the field of convalescent care. Some homes have yielded, in part, to this patent need and are admitting patients who still require

Dr. Boas was Chairman, Committee on Chronic Illness, Welfare Council of New York City, and Assistant Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University.

surgical dressings or special diets, as well as patients with heart disease. Special institutions have been established to provide convalescent care for patients with certain orthopedic disorders and certain forms of heart disease. This has been an unplanned, unregulated growth. The broader concepts of convalescent care that have resulted have not yet been clearly formulated.

The best presentation of these problems and suggestions for their solution may be found in a report written in 1934 on "Convalescent Service in Relation to a Community Health Program" by Miss Mary C. Jarrett of the Welfare Council of New York City. This report unfortunately has not been published but is available in mimeographed form. Convalescent care must be regarded as an important tool of preventive medicine and should, as Miss Jarrett suggests, be enlisted to aid all types of recovery "whether from incipient or acute illness, or from a chronic illness" which may be retarded; as a result of which disability may be curtailed.

In the field of tuberculosis such a setup actually exists, although it is not called convalescent care. Preventoria are designed to prevent the development of tuberculosis in persons, chiefly children, who have been seriously exposed to infection. The care given resembles that of convalescent homes. When a person is acutely ill with tuberculosis he is placed in a sanatorium in the hospital section where he receives intensive medical and nursing care. As he improves he gradually becomes semi-ambulant and then ambulant. Finally, although up and about and active, he is retained in the sanatorium for months to complete the arrest of his disease. This last stage is convalescent care, called by a different name.

The same principles that have been employed so successfully in combating tuberculosis can and should be extended to the treatment of a host of illnesses, particularly when poverty is an important factor in favoring the development of disease or retarding recovery. Preventorium care, designed primarily to prevent the development of disease, should be useful particularly to patients in outpatient clinics; for instance, persons suffering from malnutrition, or from subclinical forms of avitaminoses. Convalescent care of the kind given during the last months of a patient's stay in a tuberculosis sanatorium will benefit persons suffering from many other forms of chronic illness.

Chronic disease is an all-inclusive term, and here too it is necessary to agree on certain definitions before we can profitably discuss the problem. From the point of view of care needed, the chronic sick can be grouped into two large classes—those who need intensive medical and nursing care for prolonged treatment, and those whose disease is stationary or very slowly progressive, but who

are left with some disability or physical handicap which makes it necessary to give them custodial care. The latter group, those requiring custodial care, does not enter into our discussion. These patients need a permanent home adapted to their physical handicaps, not convalescent care.

The first group, the chronic sick needing active medical care, comprises a large proportion of patients in general hospitals and in outpatient clinics. Among these are many whose disease is inevitably progressive—patients with advanced cancer, with permanent heart failure, with chronically insufficient kidneys. Such patients, too, do not need convalescent care; they need permanent hospital care or its equivalent. But many chronic diseases run a course measured by years or even decades. Periods of relative well-being alternate with periods of illness. Following an acute exacerbation of the illness the proper sort of convalescent care may lead to complete or partial rehabilitation, and may delay the progress of the underlying disease. Such convalescent care is an important therapeutic and preventive agent. Many examples of patients fitting into this category may be cited: persons recovering from a period of heart failure, or from a cardiac infraction; persons with peptic ulcer whose acute symptoms have subsided under treatment; persons in a quiescent stage of chronic or subacute nephritis, whose blood protein stores possibly must be built up; persons recovering from an acute or subacute hepatitis, or an ulcerative colitis, or persons with rheumatoid arthritis.

Then there are many who happen to have a chronic illness such as diabetes mellitus, a heart or kidney ailment or high blood pressure who have intercurrent illness such as pneumonia, or an operation, and who need convalescent care after recovery from the acute intercurrent illness.

All of these subjects of chronic disease following an acute exacerbation of their illness or an acute intercurrent disorder should receive convalescent care, what I call general convalescent care. It is true that convalescent homes receiving them would have to provide more than the minimum country boarding house care that at present is all that is given in so many institutions. Proper dietary facilities and some form of minimum medical supervision would have to be provided. Important, too, would be arrangements allowing for immediate readmission to the sending hospital of any patient who again becomes ill. These measures would not add greatly to the costs of conducting convalescent homes, and would increase their usefulness in disease prevention and in rehabilitation of the individual.

The establishment of special convalescent homes for the treatment of children with orthopedic disorders and for children with rheumatic heart disease is evi-

dence that the problems that we have just discussed have received some recognition. These institutions differ from the conventional general convalescent home in that they make special provisions for the medical needs of their patients. The orthopedic home is affiliated with an orthopedic hospital and receives patients after they have been treated in the orthopedic hospital and returns them to the hospital periodically when further treatments are necessary. Cardiac convalescent homes for children are more closely analogous to tuberculosis sanatoria than to convalescent homes, because they concern themselves with the long-time treatment of children suffering from rheumatic fever and its consequences. They might be better called sanatoria for rheumatic fever. They must be prepared to give hospital care, semi-ambulant care, and ambulant care. Rheumatic fever is a chronic infection with periods of activity and inactivity. Patients must be treated until the disease has become completely inactive. At present patients with acute rheumatic fever are treated in hospitals, but as a rule they are discharged at a time when the infection is still smoldering. Far too often there is a recurrence of the acute symptoms within a few weeks after their return home, or else a smoldering infection continues uncared for, for months. At present most convalescent homes for children with rheumatic heart disease accept the patients only at a time when the disease is inactive, when they are probably least in need of such care. There is great need for institutions that will accept rheumatic patients, both children and adults, during periods of subacute or smoldering activity.

It is best to segregate rheumatic cardiac patients in separate institutions, for their medical needs differ from those of other patients with heart disease. In the case of the rheumatics, one must deal with the problem of a chronic infection. In the case of patients with other forms of heart disease the problems are primarily those of rest and nutrition. Many patients with a heart disease are run down, or are convalescent from an intercurrent malady, although their cardiac function may be satisfactory. Such persons need only general convalescent care such as can be given in a general convalescent home. There are others who are recovering from an episode of heart failure or from an attack of coronary thrombosis, who have passed the acute stage of their illness, but who need some weeks of rest and good food fully to recover their cardiac reserve. Such patients, too, need only general convalescent care, but special attention must be paid to the amount of exertion they may be allowed to undergo.

An institution is not the only means of providing opportunities for convalescence. It offers a convenient and cheap mechanism for offering convalescent care to the needy. The well-to-do do just as well in Atlantic City, Virginia, or Florida.

Foster home convalescent care for children and a method of boarding-out for adults may be very satisfactory. At present the Speedwell Society is making an interesting experiment in convalescent care for children with rheumatic heart disease. Visiting housekeepers in the home provide another method of aiding convalescence. They offer relief to an overburdened mother and give her an opportunity to complete her recovery.

As with most voluntary institutions for the sick or for the well, convalescent homes have been established to fill a local need, envisaged by some interested individual or group. Their development has never been integrated with the medical needs of the community, nor with existing health services. The chief stimulus for their growth has come from the social service field. Physicians have overlooked convalescent care as a necessary part of medical treatment and have made little use of available facilities. Today physicians are beginning to recognize convalescent care as an important implement to maintain health, prevent disease, and hasten and complete recovery from illness. Actual practice of convalescent homes has not yet caught up with this newer understanding. There is need to sharpen our concepts and translate them into practice. First of all physicians must accept convalescent homes as essential parts of the defense against disease, together with general and special hospitals, outpatient clinics, hospitals for chronic disease, and homes for the chronic sick.

As soon as this point of view is accepted the functions of convalescent homes become clarified. There will always be need for general convalescent homes designed primarily to enable disadvantaged patients to become restored to health after an acute illness. These should accept a greater variety of convalescents, in particular many recovering from acute exacerbations of chronic disease, so long as they are not seriously disabled, and have some prospect of even partial rehabilitation. Other institutions must expand their facilities, in particular their medical and dietary services, to provide for persons with persistent or recurring disorders such as diabetes mellitus or cardiac disease or peptic ulcer, for rehabilitation is often possible. The special institutions for children with orthopedic defects or with rheumatic heart disease are of still a different order, and should probably not be classed as convalescent homes.

Well-planned convalescent care, fitted into the broader structure of medical practice will be a powerful ally to the physician in his efforts to prevent disease and restore health. With chronic disease responsible for most illness today convalescent care must be realigned to meet this overwhelming and unmet need.

DISCUSSION

DR. MCEWEN stated: "I should like to comment briefly on one of the diseases touched on by Dr. Boas, namely, chronic arthritis, simply because it is not to be discussed later on during the Conference as respiratory and cardiovascular diseases will be.

"I think it is well to emphasize in this connection that the classification of chronic diseases might be subdivided into those which are essentially degenerative and those which are really low grade infections. I do not think that this is merely an academic distinction for, as Dr. Boas pointed out, the convalescent care of patients with degenerative diseases should differ in some respects from that of patients with infectional types. Arthritis is of both types, for the two chief forms of chronic joint diseases are osteoarthritis which is degenerative and rheumatoid arthritis which is infectional. It is the latter which I think is particularly important from the aspect of convalescent care.

"Dr. Boas compared rheumatic fever with tuberculosis in regard to the types of convalescent care needed, and I believe the same statements are true about rheumatoid arthritis. It has often been said that the best type of care for rheumatoid arthritis would consist of all those measures which are used to combat tuberculosis if one should substitute for pneumothorax and other mechanical methods in the treatment of tuberculosis the orthopedic and physical therapeutic measures designed to prevent and correct deformities. In other words, the essential factor is the long-continued process of building up the patient by rest and good food and sunshine which have been the time-honored measures in the treatment of tuberculosis.

"Unfortunately, there are today very few places where patients with chronic arthritis can obtain this type of long-continued sanatorium care. Usually such patients are admitted to general hospitals from which they are either returned to their homes or placed in an institution for chronic care. There are a few chronic hospitals such as Montefiore and the one newly-opened hospital on Welfare Island which fully meet the requirements of these patients. In addition, there are a few institutions for custodial care which are suitable for patients whose disease has become completely 'burnt-out' but who, because of residual deformities, are bedridden. Such patients, if their deformities cannot be orthopedically corrected, require little more than custodial care. Finally, there are the convalescent homes of the usual type which, however, are not well suited to the care of patients with rheumatoid arthritis any more than they are to the care of patients convalescing from rheumatic fever. The reasons for this, as pointed out by Dr.

Boas, are that they require too much exertion on the part of the patient and do not provide sufficient medical supervision.

"I believe, therefore, that the gap in the care of the patient with this very common disabling disease is similar to that in rheumatic fever, namely, the convalescent hospital or sanatorium—an institution similar to that which has been so widely built for the adequate care of patients with tuberculosis. There is a real need for institutions of a similar type for the care of patients with rheumatic heart disease in low grade active form and for patients with rheumatoid arthritis."

DR. CECIL, in supplementing Dr. McEwen's remarks, stated: "I wish to point out the relapsing quality of rheumatoid arthritis and rheumatic fever. We see a great many patients in our clinic and in our hospital work who apparently recover from arthritis and then, because of the urge to get back to work, take up the routine of life too soon. As a result, within six months or a year, they have an exacerbation and a return to arthritic symptoms. What we need now in this country very badly are places where the arthritic can rest for months before he is allowed to go back to routine life. In that way only can we avoid frequent relapses."

DR. BARACH stated: "The patient with bronchial asthma very frequently comes into the hospital, and in a period of a week under various types of treatment he may become free from severe asthma. That patient may within four or five days be allowed to go home, but he is in no way prepared to take up the activities of his old environment. Generally, if his residual air is tested, he is found to have a fairly marked overdistension of the lungs that might last for two or three weeks. Also, no person who for two or three weeks or for two or three months has suffered from severe bronchial asthma can possibly in a period of a week or two recover with sufficient reserve in his cardiorespiratory apparatus or his central nervous system.

"We are very apt to think with Perry Newman that in infections from two to three weeks of rest are required. In bronchial asthma, however, we are apt to release patients much sooner. We see in all of our hospitals repeated readmissions of the patients with severe bronchial asthma and very rarely does it occur to us to send that patient to a convalescent home. For a period of years we have been analyzing the recurrences of severe broncho-asthma. One strange fact is that frequently a patient who has been told that he can return home in the course of three or four days, has a recurrence of broncho-asthma within three

or four days. In that way we have been able to exclude the factor of local environment providing an allergic-offending substance. Nor do I think it is just the idea of going home. I think that patient who has been exhausted and who has got up and started to walk around in the wards or even on the private floor begins to get a recurrence of severe asthma because he has not had an adequate rest.

"I think probably our hospital readmission rate would be less if we could put those people where they could rest for two or three weeks, or perhaps for four or five weeks, in a convalescent home."

DR. MOCK stated that in Chicago there have been spasmodic demonstrations of interest in convalescent care, dating back to a committee report on the Need of Rehabilitation Care in Chicago which was made to the Institute of Medicine in 1923. Recently interest in this subject has been renewed there, with the result that the Cook County Hospital is now contemplating the building of a large convalescent center. The Institute of Medicine, realizing the need for convalescent care of all types of patients, from the private as well as the public hospitals, has appointed a committee to work on the problem of convalescent care in Chicago.

Dr. Mock pointed out that in every large community there are hundreds of individuals injured in industry and receiving compensation who could be restored to health more quickly in properly constituted convalescent homes. He called attention to the growing prevalence of low back pains among working men and stated that these conditions are often ascribed to injuries and thus result in compensation awards. The treatment given to patients with these pains is often as farcical as is the alleged etiology. In the majority of instances the low back pain is inherent in the individual and the occurrence of the injury is only coincidental.

Dr. Mock suggested that the attention of insurance companies and industries should be called to two facts: first, that for cases of alleged injuries a better diagnosis and more adequate treatment is needed; and, second, that adequate convalescent care would restore these patients to working ability without the great expense which is involved in the prolonged treatment now in vogue. The acceptance of this knowledge, Dr. Mock stated, might result in a source of income for convalescent work.

DR. BARKER stated: "Dr. Boas and those who have discussed his paper have shown very clearly the necessity for convalescent homes, place intermediary

between the hospital for the treatment of acute or severe processes and the home of the patient.

"The hospital wards are so crowded now that it is necessary to get people out of them as soon as possible in order to make room for the more severely sick; yet, the patients thus discharged are very often not ready to go home. The convalescent home is the place for them. We have largely to thank social workers for the development of this convalescent-home idea.

"It is difficult for me to see how convalescent homes can be properly run without medical supervision. Of course, the hospital that discharges a patient should give him an outline of the procedures that should be followed during the convalescent period and these could be carried out by the authorities in the convalescent homes. But that is not enough. Things turn up that require medical decisions. Even if there cannot be a resident medical man in every convalescent home, it seems to me that competent medical men should make periodical visits to every convalescent home to make sure that everything is going right in the management of the patients.

"Someone spoke of the fact that patients often leave the convalescent home too soon on account of the urge to get back to work. That is important but there is another danger. The delightful irresponsibility at the convalescent homes will sometimes keep patients there longer than they ought to be there and a medical man should see to it that when the time comes for a patient to take up his duties outside of the convalescent home he should leave it. Whatever additional attention may be necessary can be given by the family physician. Thus, some people leave convalescent homes too soon whereas others stay too long."

DR. MENNINGER stated: "An aspect of the matter that has not been stressed is the importance of psychotherapy in the chronically ill. Dr. Mock and Dr. Barker left the impression that it is the attitude of many physicians that the chief reason why patients remain chronically ill, particularly those who are getting some compensation for it, is the ostensible and exterior one of gaining money. It would be regrettable if this overemphasis were again to become prevalent.

"The continuation of chronic illness, presents, no doubt, in many cases the easiest solution of economic difficulties. However, it also represents a good way out of the psychological difficulties, and to ignore the significance of psychological difficulties in pathogenesis, is, I think, to ignore and neglect a function of medicine which is in our hands if we but choose to use it. It is something that we now know a little about, something that we wish we knew more about, but something which, it seems to me, is of equal importance to that of the nursing service, the

prescription of diet, or the administration of drugs. In other words, I think the physician must not only supervise but he must attempt to understand why, for reasons unknown to the patient perhaps, his patient is required to remain ill in spite of the fact that he loses out on many of the satisfactions of life which seem to us more desirable."

DR. PEPPER concluded by emphasizing the need for a definition of the point at which convalescence begins. He stated that the lack of understanding of the true meaning of convalescence and its implications in terms of adequate care has resulted in an unfortunate situation in Philadelphia where a convalescent home receives some of its support from a charitable fund. This fund is threatening to cut down on the financial assistance which it has given to that home because the home is spending too much money on the care of the patient. The fund objects especially to the home paying a physician to visit the inmates once a week. The community fund's definition of a convalescent home is "a place where the individual needs no special or medical care." Such problems would not arise if we could define the point at which a patient may appropriately be shifted from the hospital to the convalescent home.