Between Illness and health

What Happened to Convalescence?

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Metropolitan Convalescent Hospital, Walton-on-Thames. Coloured wood engraving, 1854 (Wellcome Collection)

Modern medicine has forgotten the transition between sickness and health. Worse, patients are often discharged for reasons other than their own welfare and recovery. Governed by the profit motive, insurance reimbursement and government guidelines the last person on the list of priorities is the patient. However historically that transition between illness and recovery, sickness and health was recognised as critical in re-entering home and work spaces. What was this convalescent stage and how did it improve outcomes? Why did modern medicine sacrifice this integral part of the healing process.

Definitions

Convalesce means to:

- Recover one’s health and strength over a period of time after an illness or medical treatment (Oxford Dictionary, 2018)
- To rest in order to get better after an illness (Cambridge Dictionary, 2018)

You look up synonyms for the word convalescence and you see words such as

- recuperation, recovery, return to health, process of getting better, rehabilitation, improvement, mending, restoration

Convalescence is the gradual recovery of health and strength after illness or injury, has become something of a lost art in modern society.

This shift away from the traditional practice of allowing time for recovery has occurred due to several factors:

Changing Medical Landscape

The decline of convalescence can be partly attributed to the significant progress made in treating diseases

With advancements in medicine and the availability of effective medications, there's an expectation that recovery should be quick and complete.

Societal Pressures

Work Culture:

In today's fast-paced world, there's an increasing pressure to return to work as soon as the acute phase of an illness has passed

. This "always on" culture, coupled with the ubiquity of mobile phones and social media, has made it difficult for people to truly disconnect and focus on recovery.

Expectations:

Society has developed expectations that:

- Medication will quickly resolve health issues
- Illness duration should be short

- People should return to work and activities promptly after being sick

Economic Factors

Healthcare System Constraints: In some instances, shortages of hospital beds or trained staff have led to a more rushed approach to patient care, moving away from a focus on convalescence.

Loss of Traditional Practices

The concept of convalescence, once a common feature in 18th and 19th-century literature and medical practice, has largely fallen out of favor.

The idea of a gentle, gradual return to health, which might have involved reading, resting, and sipping broth, has been replaced by a more hurried approach to recovery.

Potential Consequences

The loss of convalescence as a practice may have implications for long-term health outcomes. Some experts suggest that embracing this period of slow recovery could offer benefits for conditions such as long COVID

Additionally, the rush to return to normal activities without proper recovery time may lead to relapses or prolonged illness

In essence, convalescence has become a casualty of our modern, fast-paced society, where the emphasis on productivity and quick fixes has overshadowed the importance of allowing time for full recovery and restoration of health.

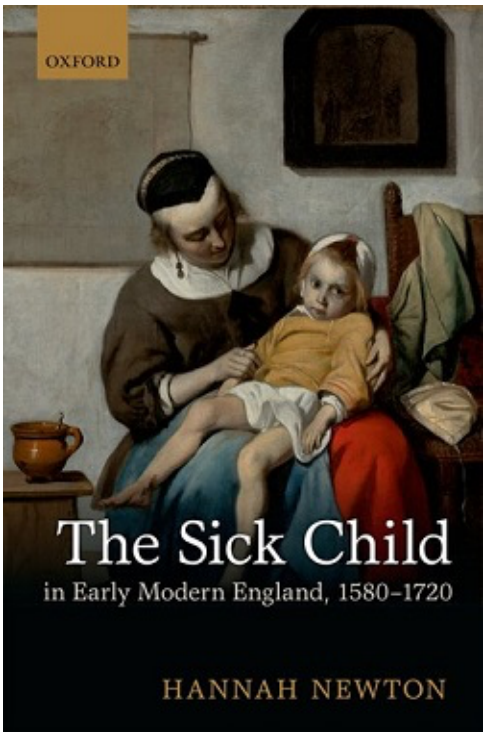
History

The ancient origins of convalescence

We think of convalescent care and associate it with Florence Nightingale and with 19th-century European tuberculosis sanatoria immortalized in novels like Thomas Mann's *The Magic Mountain.*

But the concept has older origins. The word "convalesce" dates to the late 15th century, and derives from the Latin convalescere, a combination of com,

meaning "together," and valescere, "to grow strong." The English word convalescent appears in a 1656 dictionary, but was often used interchangeably with phrases such as "the recoverer" and "the weak party,"



Early modern diaries and letters are replete with complaints about the state of the body at following illness. Hannah Newton asks how doctors and laypeople measured the patients' growing strength following illness and analyses the physiological processes through which this restitution was thought to occur.

It shows that both the measures and the mechanisms for the restoration of strength were intimately connected to the 'six Non-Natural things': excretion, sleep, food, passions, air and exercise. Patients' sleeping pat erns, appetites for foods, and emotions along with other inclinations and behaviours that related to the Non-Naturals, were used to track their progression on 'the road to health'.

Medical practitioners and the patient ' s family sought to regulate each Non-Natural in order to promote the body ' s restoration, and guard against possible relapse. She argues that this regulation, together with the assiduous

monitoring of the patient ' s growing strength, constitute a concept of convalescent care.

In a study entitled: *The Future is Convalescence: Rethinking Recovery and the End of Covid–19* Avril Tynan[1] writes:

The progress and effectiveness of potential Covid–19 vaccines in the last few weeks have brought a new glimmer of hope to the closing months of 2020. While much of Europe remains under restrictions, or is tentatively emerging from a second lockdown, the new AstraZeneca-Oxford, BioNTech-Pfizer and Moderna vaccines are offering hope of future biomedical, social and economic recovery. Yet, as many of those who suffered from Covid-19 can attest, the process of recovery is uncertain, unsteady and unknown. Increasing attention to the ongoing effects of "long Covid" or post-viral fatigue syndrome amongst those who have suffered and apparently recovered – from a clinical perspective – from Covid–19 emphasises the ambiguous future that lies ahead.

Similarly, our increasingly optimistic discourses of social and economic recovery overlook the almost inevitable effects of "long Covid" on our futures. Although soon we may no longer live with the physically manifested symptoms of the disease, we will continue to inhabit an ambiguous, post-viral in-between that fails to offer the cathartic notions of progress or advance we associate with full recovery.

To speak of a recovery from the Coronavirus pandemic is mistaken and misleading. Our future will not be one in which recovery is immediately – or perhaps ever – achieved; instead, our future is convalescence, ***"a time in which one does not, in the manner of accomplishment, enter a state of health; rather, it concerns a time of getting over in which the source of the illness never really withdraws completely."***[2]

Yet the state of convalescence offers an appropriately cautionary sense of a more realistic future world in which complete recovery is always deferred.

[1] https://blogs.bmj.com/medical-humanities/2021/01/07/the-future-is-convalescence-rethinking-recovery-and-the-end-of-covid-19/

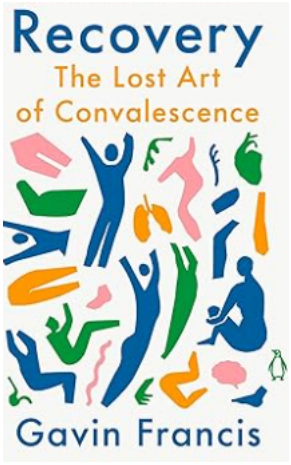
[2] James Risser, "On the Continuation of Philosophy: Hermeneutics as Philosophy," in *Weakening Philosophy: Essays in Honour of Gianni Vattimo*, ed. Santiago Zabala, 184–202 (Montreal: McGill-Queen's UP, 2006), 187–88.

Convalescence itself, however, must first be understood not as a cathartic re-emergence from a state of illness, but rather as "a hazy yet paradoxically crystal-clear state between sickness and health".[3]

As Barbara Spackman suggests, "convalescence is a space in-between", an ambiguous site in which symptoms of both health and illness intertwine and commingle.[4] Convalescence, therefore, and particularly the convalescence of Coronavirus, can be better understood as a hermeneutic that does not forget or leave behind the experience of illness but incorporates it in the ongoing life of understanding.

Following James Risser, convalescence "indicates that the recovery is a matter of a recovering in which the recovery itself remains outstanding". (op cit 190)

Risser argues that in the postmodern condition of hermeneutic convalescence we do not overcome the past of illness but rather overcome "the very idea of overcoming" and challenge modernist notions of permanent progress and advancement: "in its mode of convalescence hermeneutics cannot produce a new age; it cannot turn over to a new beginning".



Gavin Francis's work defines recovery as a discrete therapeutic entity that deserves our full attention and why we should never give up trying to get better, even when it seems we couldn't get much worse. Recovery is a difficult

[3] Barbara Spackman, *Decadent Genealogies: The Rhetoric of Sickness from Baudelaire to D'Annunzio* (Ithaca: Cornell UP, 1989), 42.
[4] "The Scene of Convalescence." Decadent Genealogies, 2018, 33–104.

but essential part of what makes us human. In his case studies, he shows how it's the time that recovery takes that is, over and over again, the greatest challenge to patient and care-giver.

To show this, Francis recalls the rich history of slow-paced recovery and of the places and people who enabled it. Not all of it was effective (the milk cures that confined patients to bed for weeks did much harm and no good) but the underlying recognition of taking our time to rebuild ourselves is a profound insight into human regenerative capabilities. We used to know this, but somewhere in the white heat of changing medical technologies, we forgot and came instead to expect the instant and the effortless.

He carefully delineates different forms of recovery that humans are required to undertake. He looks at recovery from long Covid, from profound stress and unhappiness, from misfortune. Most powerfully of all, he describes how recovery is possible even if the biological causes of illness cannot be fixed. Recovery in the context of terminal illness is about resolution and the achievement of a kind of equilibrium in the remaining time left to a life-limited human. Francis draws on both the writings of Oliver Sacks and from his own patient list to relate the experiences of how it is to be both dying and, in truly remarkable ways, recovering new forms of humanity, even if only for a short while.

'The milk cures that confined patients to bed for weeks did much harm and no good' by Carl Olof Larsson

The Victorian poor had access to charitable hospitals, but returning to overcrowded slums had a pronounced impact on their chances of recovery. As the population of working-class patients treated in city hospitals increased,

reformers and philanthropists established convalescent homes where these patients could recuperate away from the stresses of their normal working lives. One of the first was at Walton-on-Thames, formed in 1840 from the old Carshalton workhouse.

The answer lay in changing attitudes to recovery, Before the advent of modern medical care in the 20th century people were vulnerable to a raft of infectious diseases from typhoid to tuberculosis. Those who were fortunate enough to survive infection were expected to take a long time to recover fully, Krienke found. This process of restoration—a stage between acute illness and full health—was a major focus of physicians and families. For centuries, the care of convalescents came with its own set of theories and rules, intended to prevent relapse and integrate patients back into normal life.

But with medical advancements, tolerance for long recovery waned.

Why we need recovery time

The pandemic offers an opportunity to reconsider the patient's experience, suggests Sally Sheard, historian and executive dean of the Institute of Population Health at the University of Liverpool, as well as the kind of time we are willing to allow for recuperation. *"One of the clearest messages from my work on convalescence is that you cannot rush the process,"* she says.[5] In the United Kingdom, some COVID-19 patients were discharged too fast, to free up beds, while others were delayed in hospital too long because they had no help at home, she says, adding, "so maybe we need halfway or recovery homes," not unlike older convalescent homes.

The disposition of convalescence due to its lack of expedience

Ivan Illich[6] was well ahead of his time in identifying and classifying the health hazards of the "medicalisation of society". In the mid-1970s he used medicine as an example of his general thesis that industrialisation and bureaucracy were appropriating areas of life previously regarded as personal. In particular, he identified how drugs and other medical technologies remove personal responsibility for suffering and create dependence on health care, which itself has a wide range of hazardous slide effects. The flip side of this coin is the

[5] https://www.liverpool.ac.uk/people/sally-sheard/publications#tabbed-content
[6] Illich I. Medical nemesis. *Lancet*1974;i:918–21.
Illich I. *Limits to medicine: medical nemesis—the expropriation of health.* London: Marion Boyars, 1976.

trauma caused by the system excreting the patient back into the workforce without regard to anything other than their utility for society and little regard to the intangible effects of recovery and time.

World War II: wounded soldiers convalescing at Preston Hall, Aylesford

Health equity

The World Health Organization defines *health equity* as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[7] Healthy People 2020 defined a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" and stated that health disparities "adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

There has recently been an increased awareness of how social factors are contributing to health inequities and disparities. These are the "nonmedical

[7] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3

factors that influence health outcomes" and involve the "conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life." For example, the forces and systems can include economic policies, government agendas, and social norms.

In hospital in patient planning, there must be a proper medical diagnosis and a plan to get the patient out of hospital as quickly as possible. Convalescence and recovery don't count. Indeed, as Henry Marsh points out,[8] these words are generally absent from the indices of medical textbooks. Yet common sense and experience tell us that they are a vital part of illness, and this truth has become blindingly obvious with Covid and its long-term complications. Illness is not a binary experience where you are either ill or well. You have to recover, and that takes time, and is often a far from simple process.

Although Nightingale believed in the mistaken miasmatic theory of illness – that infections were spread by foul air – and was almost certainly a dualist, believing that mind and matter were separate entities, she was remarkably prescient. In her *Notes on Nursing*, published in 1859, she wrote:

Little as we know about the way in which we are affected by form, colour, by light, we do know this, that they have a physical effect. Variety of form and brilliancy of colour in the objects presented to patients are actual means of recovery.

It is now well known that mind and matter are not separate entities.[9] Our immune systems, for instance, have complex connections to our brains – admittedly, poorly understood – and states of mind can have a profound effect on "physical" illness, just as "mental" illness can have profound effects on the body. And yet this knowledge has been largely neglected in healthcare in recent decades.

Francis writes that the medicine in which he was trained assumes that once the crisis of illness has passed, the body and mind find ways of healing

[8] https://www.newstatesman.com/culture/books/2022/01/how-we-lost-the-art-of-getting-well

[9] **The Matter With Things: Our Brains, Our Delusions, and the Unmaking of the World** 2 vols Perspective Publishing March 1, 2023

themselves. As a GP who has observed thousands of patients struggling to recover from illness, he knows this isn't true. Recovery, he argues, needs time and guidance. I suspect that he is the kind of GP most of us long for. He sees his role as a "guide in the landscape of illness" and not as a mere prescriber of pills.

As recovery requires time, Francis writes of the importance of telling patients to allow themselves this luxury, without guilt, and that they should not feel they are malingering. "Self-compassion," he writes, "is a much-underrated virtue." Even the small number of deliberate malingerers (according to Francis, government statistics show that only 1.7 per cent of sickness benefit claims are fraudulent, despite what the tabloid press might claim) suffer from self-reproach.

The great 19th-century German doctor Rudolf Virchow – a giant of modern medicine – wrote that doctors are "the natural attorneys for the poor". Francis describes how for so many of his patients, recovery – and he correctly makes no distinction between physical and mental illness – is inextricably tangled up with their work.

Convalescence: the forgotten phase of illness recovery

U.K. philosopher **Alain de Botton**, an explorer of the *'philosophy of everyday life.'* writes:[10]

"People can accept you sick or well. What's lacking is patience for the convalescent."

Convalescence. It's the gradual return to health while you still need time to recover from illness or medical treatment, usually by resting. For patients, it's that fuzzy grey area in between feeling acutely ill and feeling 100% healthy again. The term comes from the Latin *convalescere:* "to grow fully strong."

[10] https://www.alaindebotton.com/

Carolyn Thomas writes:[11]

Most garden-variety convalescence is mercifully short. After spending a few days in bed with a flu bug, for example, you might feel a bit weak or shaky for a while. Not exactly sick anymore, but not yet 100%. Other forms of convalescence, however, may take weeks, months or even years of recuperation. And with some chronic and progressive disease diagnoses, everyday life can start feeling like one long endless period of convalescence – with good health merely a dim memory. The difference: unlike the historical practice of viewing convalescence as a distinctly separate and important stage of illness recovery, today's convalescents may simply feel like they're being forced to very quickly adjust to the ***"new normal"*** *of life.*

There was a time when doctors fully accepted the need for ill people to be cared for in a way that would help them adequately recuperate. And the number of days patients are kept in hospital before being discharged home has been steadily declining for decades. Reduced **length of stay** – the darling of cost-cutting hospital administrators everywhere – is now suspected of being a factor in the disturbing rates of costly and dangerous hospital readmission within 30 days after discharge home.

For example, a 2013 study from Boston University School of Public Health published in the journal *Medical Care Research & Review* found that for heart patients, even a 1-day increase in length of stay yielded estimated reductions in later hospital readmission rates up to 18% for heart attack patients and up to 8% for heart failure patients.[12] Researchers wrote:

"Increasing length of stay for some patients may be a means of improving quality of care by reducing readmission during the 30-day post-discharge period."

[11] https://pubmed.ncbi.nlm.nih.gov/34718807/
[12] Kathleen Carey et al. Medical Care Research & Review, vol. 71, 1:pp. 00-111. October 16, 2013.

Royal Sea Bathing Hospital at the beach resort of Margate in East Kent

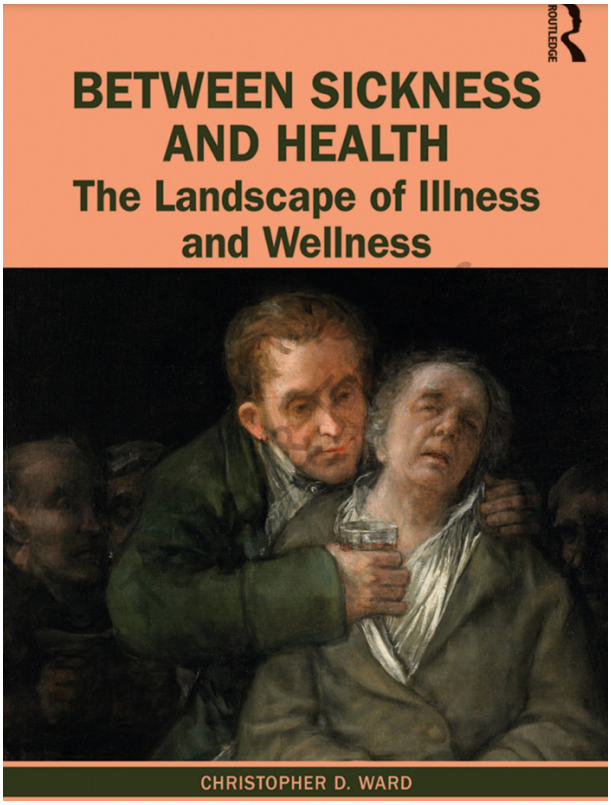
In its earliest days, Royal Sea Bathing Hospital doctors believed that sick people – usually survivors of some form of tubercular infection – could benefit from the healing effects of invigorating sea bathing, brisk salt air and good nutrition that would help them become strong enough to go back home.

Similar convalescent homes built over the next two centuries provided weeks or months of respite care at the seaside, in the mountains, or in the countryside in an institutionalized yet healthful environment to people recovering from injury, trauma or surgery.

Historically, a convalescent home might have also been referred to as **sanitorium**. An article published in the Glasgow Medical Journal back in 1859 was called *"Reasons Why Sanatoria Should Be Established On The River Clyde For The Sick Poor Of Glasgow."*

Meanwhile, convalescent or sanitorium care was largely seen as a charitable kindness, especially as a break from extreme poverty and the harsh social/environmental conditions that in so many cases both worsened ill health and impeded recovery.

When a tuberculosis epidemic swept through North America in the early 1900s, many cities advertised themselves as ideal destinations for those diagnosed with *"the white plague".* There were many convalescent homes in the dry, sunny state of Arizona, for example, modeled after European non-urban resorts of the time like the Royal Sea Bathing Hospital. By the year 1920, over 7,000 people had come to Tucson alone to recover from tuberculosis. So many patients with TB arrived there, in fact, that a form of tent city sprang up to take advantage of the area's dry climate and plentiful sunshine, both recommended by physicians as curatives.

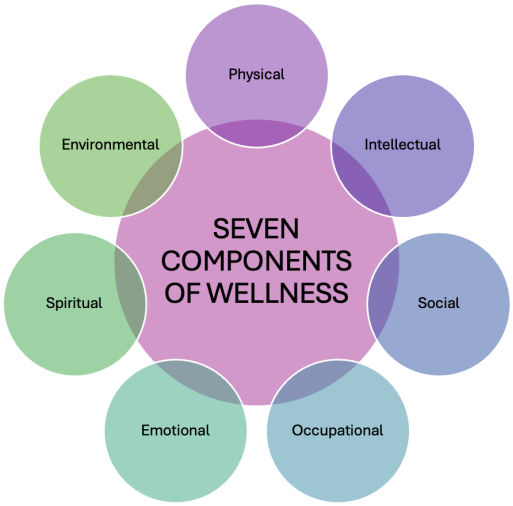


Between Sickness and Health is about illness rather than disease, and recovery rather than cure. The book argues that illness is an experience, represented by the feeling that 'I am not myself'. From the book's phenomenological point of view, feelings of illness cannot be 'unreal' or 'fake', whatever their biological basis, nor need they be categorised as 'physical', 'psychosomatic' or 'psychiatric'. Dr Ward challenges the disease-centred ethos of medicine and medical education. It demonstrates that a clearer conception of illness, as distinct from disease, is therapeutic. The feeling that 'I am once again myself' can return, in some degree, whatever state the body is in.

Resilience becomes more available when it is seen as a set of personal skills that can be developed, rather than as an inborn trait. Possibilities of wellness are enhanced by recognising that medical and other therapies can either support or impede recovery, as can human relationships and the socio-political environment.

He reviews factors that tend to block recovery by perpetuating feelings of illness, or by reinforcing the identity of illness. For many people the possibilities of recovery are obviously limited for biological reasons. Less absolute obstacles include factors stemming from an individual's attitudes and history; from family and other close relationships; and from social structures such as healthcare. Indifference to the possibility of recovery is one personal obstacle to recovery.

Another is the fear of losing the advantages sometimes associated with illness, such as the sense of safety and the defined identity that a sick role offers. Positioning provides an account of relational barriers to wellness, showing how, for example, other people may hold someone in the position of patient or carer. Social structures do the same thing on a larger scale, making it more difficult to escape from illness. For example, when the only sources of help are health services, a non-medical description of distress may be unthinkable.



Lived experience practitioners and the medical model: world's colliding?[13]

[13] Louise Byrne, Brenda Happell & Kerry Reid-Searl (2015): Lived experience practitioners and the medical model: world's colliding?, Journal of Mental Health 11 Dec 2015.

Mental Health model

Consumers[14] of mental health services and mental health professionals have been found to hold differing beliefs and **concepts** about what is valuable and effective in service provision (Aston & Coffey, Kogstad et al.)[15]

Most participants in a recent study viewed the continuing dominance of the **medical model** as the most significant barrier to the success of mental health reform, which in turn impacts strongly on LEP roles. The foundation of the **medical model** approach is the DSM or Diagnostic and Statistical Manual of Mental Disorders which psychiatrists use to categorize the mental health experience of consumers.

The service consumers receive, often with a strong pharmaceutical focus, is guided by the diagnosis drawn from the DSM which has been described by both consumers and mental health professionals as pathologizing distress and maintaining **medical model** dominance within the mental health system.

Over time, research has shown the damaging ramifications of adopting an "**illness** identity" and feeling limited in life choices as a result of diagnosis with increased risk of suicide, decreased hope and self-esteem, and limitations on potential social roles identified .[16]

The release of the DSM – V and even more recently, highlighted the disconnection **between** the life experiences of people and the **medical model** approach, with vocal concerns about the validity of the document expressed by mental health professionals and consumers alike.

[14] Aston V, Coffey M. (2011). Recovery: What mental health nurses and service users say about the concept of recovery. J Psychiatr Ment Health Nurs, 19, 1365–2850.
[15] Kogstad RE, Ekeland T, Hummelvoll JK. (2011). In defence of a humanistic approach to mental health care: Recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change. J Psychiatr Ment Health Nurs, 18(6), 479–48.
[16] Yanos PT, Roe D, Lysaker PH. (2010). The impact of illness identity on recovery from severe mental illness. Am J Psychiatr Rehabil, 3(2), 73–93.