RECOVERY

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RECOVERY

The Lost Art of Convalescence

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For my teachers
(in other words, my patients)

I enjoy convalescence. It is the part
that makes the illness worthwhile.

—G. B. Shaw

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NOTE TO THE READER

This is a book about illness and recovery, about healing and convalescence. I'm a general practitioner trained in a Western medical view of the body, and the reflections that follow are grounded in that tradition. Illness is as much about culture as it is about disease, and our ideas and expectations of the body profoundly influence the ways in which we fall ill. They also influence our paths towards recovery. A Faroese farmer, a Thai engineer, a Peruvian taxi-driver and a Sudanese schoolteacher will all have different traditions of the body and of health, and their paths to recovery can be comparably diverse.

What follows is a series of explorations of recovery and convalescence seen from within

a particular medical tradition – my own as a European, twenty-first-century, general medical practitioner. While I acknowledge the value and the virtues of alternative approaches to the body and to illness, I will leave discussion of them to others trained in their use.

The patient stories that follow are either so commonly encountered as to risk no betrayal of confidence, or have been disguised beyond any possibility of recognition. Confidence means 'with faith' – we are all patients sooner or later; we all want faith that we'll be heard, and that our privacy will be respected.

1

THE LOST ART OF CONVALESCENCE

When I was twelve years old I had a stupid accident. I was cycling home from town with friends when a colossus of a lorry passed too close, causing me to swerve my bicycle. It was over in a moment: I put out my left foot to steady myself, and my heel jarred hard against the kerb. The impact tumbled me off the bike and onto the pavement where I lay in the dust, relieved to be alive, but unable to straighten my leg. The lorry didn't stop.

My pals pedalled off to get help, and after what seemed an age, but was probably only twenty minutes, my mum turned up to take me

to hospital. An X-ray showed that the topmost piece of my shin bone, the 'tibial plateau', had splintered, and a fragment had become lodged at the back of my knee joint. And just as a sliver of wood can hold back a heavy door, that tiny fragment wedged my knee in a bent position.

I was taken to an operating theatre where, under anaesthetic, a surgeon wrenched the knee back and forth until that splinter of bone fell into place. A cylinder of plaster was rolled around the leg, I was given some crutches, and told to come back in the autumn.

To be immobilised in plaster through the summer holidays would have its challenges for any twelve-year-old, but it was once the plaster was removed that my journey of recovery really began. A metamorphosis had occurred. The knee had become bulbous, and my thigh and calf seemed by comparison stick-like, wasted and malnourished. A fine pelage of hair had sprouted under the protection of the plaster, bizarrely dark against skin that was now as white as bone. When I tried to walk, the knee wobbled and gave way.

It took months for my leg to feel like my own again; months of boring, punishing exercises to build up the muscle. Relearning to walk was a process led not by doctors, but by a pair of brisk and cheerful physiotherapists whose department I remember as one of too-bright lights, wipe-clean benches, weights, straps and gym bars on the walls. I can recall the distinctive disinfectant smell of the floor cleaner, and the regular company of a man I'd met previously on the ward who had shattered his leg in a motorbike crash. He was big, with a black moustache and stubble, and with a delicate gold hoop that hung from one of his earlobes. As we groaned and sweated together, lifting weights attached to our ankles, he joked about how I was recovering more quickly than him.

When I think of that period of convalescence now I remember afternoons at home reading in the sunshine, and doing my physiotherapy exercises at first tentatively, then with more confidence. The days were busy with sounds: of birds in the garden, cars in the distance, wind moving through the barley of

the field behind the house. For twelve years my body had rarely stopped, and it seemed unnatural to have it rendered so motionless, as if with my injury the nature of time itself had warped and transformed. The flow of my life had been stilled, but it was that very stillness that gave me the opportunity to heal.

It wasn't my first experience of convalescence. A couple of years earlier I had woken one morning with a hammer-blow headache and a churning in my stomach. I suddenly knew the truth of the saying 'he couldn't lift his head off the pillow'. My GP was called for, a kindly man of the old school who took one look and, suspecting meningitis, sent me urgently to an infectious diseases hospital an hour's drive away, where the diagnosis was confirmed. I spent eight days and nights in that hospital, in a room with large windows that gave on to trees and afternoon sunshine.

In the niches of my memory I carry no images of the doctors, only one of a nurse in a sky-blue tunic, her black hair in a bun, her

kind face lined with smiles. An iron-framed bedstead, glaring white sheets, and again, that smell of floor disinfectant. A window in an internal wall of the sick room gave on to a nurses' station – even when my parents were away I was kept under surveillance. Though my mum and dad took shifts to be with me for most of the day they also had my brother to attend to, and I spent many hours alone in silence waiting for them to come; waiting for home.

With a limb it seemed possible to objectify the part that needed recovery, to look down on the leg and say *'that's* the problem, right *there*'. Working to build up the leg was effortful but also visual, my progress inscribed in the bulk of my thigh, the colour of my skin, the comparison with the healthy leg at its side. My recovery from meningitis was far more difficult to grasp, the edges of what recovery *meant* were far less clear. A languorous fuzzy-headed exhaustion dominated my days, burnishing the world with the bright haze of a dream or a hallucination. My body was in convalescence, but

the process itself felt disembodied, ethereal, as much mental as physical. As I look back on it now, it's clear that it was my first experience of the complexities of convalescence, and how it can and must take very different forms with different illnesses, and between different people.

Six years after my leg recovered I went to medical school to train to be a doctor. A decade after that I was working in a brain injury unit, as a junior member of a team caring for a relentless flow of broken people – mostly young men who had been injured through reckless driving, falls or fights. I saw how quickly their bones could heal, but how much longer it took for their brains to do the same. Once the initial crisis of injury was over – blood clots removed, pressure relieved, skulls plated and wired – they would be moved to a 'rehab ward' where they might stay for months at a time, gradually relearning what were known as ADLs – 'activities of daily living': bathing, dressing, cooking and so on. For some, those 'ADLs' would include relearning to walk or to talk.

The word *rehabilitation* comes from the Latin *habilis*, 'to make fit', and carries the sense of restoration: 'to stand, make, or be firm again'. The aim of rehabilitation, then, was to make someone as fit as they can be, to be able to stand firmly on their own two feet. And though recovery was the clinicians' ultimate aim, it's curious that the words 'recovery' and 'convalescence' are generally absent from the index of medical textbooks. As long ago as the 1920s, in her essay 'On Being Ill', Virginia Woolf wrote that we lack a mode of writing about illness, that it is 'strange indeed that illness has not taken its place with love, battle, and jealousy among the prime themes of literature'. A century on, her assertion no longer holds true: we do have a literature of illness. But I'd argue that we still lack a literature of recovery.

The medicine I was trained in often assumes that once a crisis has passed, the body and mind find ways to heal themselves – there's almost nothing more to be said on the matter. But after nearly twenty years as a GP I've often found

that the reverse is true: guidance and encouragement through the process of recovery can be indispensable. Odd as it seems, my patients often need to be granted permission to take the time to recover that they need. Illness is not simply a matter of biology, but one of psychology and sociology. We fall ill in ways that are profoundly influenced by our past experiences and expectations, and the same can be said of our paths to recovery. I have learned much from those other clinicians – the nurses, physiotherapists and occupational therapists – who have most helped my patients, and am always being reminded of how much there is still to learn.

The therapists in the brain injury unit knew that convalescence is anything but a passive process. Though its rhythms and its tempo are often slow and gentle, it's an *act*, and actions need us to be present, to engage, to give of ourselves. Whether it's our knees or skulls that need to heal from an injury, or lungs from a viral infection, or brains from a concussion or minds from a crisis of depression or anxiety,

I often remind my patients that it's worth giving adequate time, energy and respect to the process of healing. We need to take care over the environment in which we're attempting to heal, celebrating the importance of nature and the natural world and recognising the part it can play in hastening recovery. Many patients I've known over the years have found a way to make sense of even a very difficult illness journey. When an illness or disability is incurable it can still be possible to 'recover' in the sense of building towards a life of greater dignity and autonomy.

There is no hierarchy to suffering, and it's not possible to say of one group of conditions that they deserve sympathy while another group deserves to be dismissed. I've known patients whose lives have been dominated, for years, by the grief of a failed love affair, and others who have taken the most disabling injuries, pain, indignity and loss of independence in their stride. Though it can be tempting to resent someone whose illness appears to be less serious than our own, or

to judge ourselves harshly when others seem to be coping with more challenging circumstances than we are, comparisons are rarely helpful. Neither should we be anxious to set out a timetable of recovery: it's more important to set achievable goals.

As a doctor, sometimes all I can do is reassure my patients that I believe improvement of *some kind* is possible. The recovery I'm reassuring them of might not be biological in nature, in terms of a resolution of their condition, but rather an improvement in their circumstances.

What follows is a series of reflections on recovery and convalescence gleaned from my own experience of illness, and of thirty years in training and in practising medicine. It contains much that I wish I'd known when I set out on my career, while acknowledging that there is always more to know. Every illness is unique, which means that all recoveries must also be in some sense unique, but I have tried to set out some principles and waypoints that have proven helpful over the years to guide me, and my patients, through the many landscapes

of illness. It's a place that all of us must visit, sooner or later; from time to time we all need to learn the art of convalescence.

2
HOSPITALS AND RECOVERY

We need time to recover, but we also need a safe space in which to do it. A couple of hundred years ago there were few hospitals, and infectious disease was the main cause of illness. Convalescence, where there was time for it, happened at home. Throughout the nineteenth century it became ever more evident that offering a bed, and some basic hygiene measures, improved a convalescent's odds of survival. Between 1800 and 1914 the number of hospitals in the United States increased from just two to over five hundred. Between 1860 and 1980 the UK quadrupled its hospital beds. On both sides of the Atlantic these burgeoning hospitals were built on the principles

extolled by Florence Nightingale, who wrote in her *Notes on Nursing* (1859) that hospitals should 'signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet'. She also thought that the windows should look out on something green, growing and alive (a recommendation that has been borne out through modern research). She developed new ways of tabulating survival to better reveal the factors that most influenced recovery, and began to show that, when it comes to saving lives, good nursing is just as important as medical and surgical interventions.

In November 1854 Nightingale and her team of nurses had arrived at a military hospital in Turkey to find two thousand injured men dying in squalor – in those days more soldiers would die from infections than from bullets. One of her first acts was to order three hundred scrubbing brushes, and to requisition more nurses: 'I am a kind of General Dealer,' she wrote, 'in socks, shirts, knives and forks, wooden spoons, tin baths, tables and forms,

cabbages and carrots, operating tables, towels and soap.' At the time of her arrival, one out of every two or three men were dying of their injuries, and although the military brass of her day disapproved of her efforts, they changed their minds when the death rate dropped to something more like one in fifty. *Convalescence* itself comes from a word meaning 'to grow in strength'. For Nightingale, this had an emphasis beyond the descriptive: the only way to beat infectious disease was to strengthen the body to fight it, keep wounds clean, and to optimise the environment around the patient to make it more conducive to healing.

Between 1879 and 1900 the bacteria responsible for the infectious miseries of mankind were identified at the rate of about one a year. As the biology of infectious disease began to be understood in ever-greater detail, death rates began to fall. And later, when antibiotics were discovered, the near-miraculous cures these medications effected meant that survival rates soared further. Slowly, through the latter half of the twentieth century, the idea of

good nursing as the key to recovery began to fade. Time in hospital beds began to be seen as inefficient, wasteful and unnecessary. Some clinicians began to suspect that all that was needed was the right prescription.

Average lifespans around the world are now double what they were in 1900. But through the latter half of the twentieth century, as more and more of us began to live into years of frailty and dependency, hospital bed numbers tumbled. In the UK, we've halved the number available since 1988 (from 300,000 to 150,000), a statistic that's emblematic of a trend across the developed world. It's not possible for me now, as a GP, to admit a frail, elderly patient somewhere safe for nursing care and convalescence alone – the hospital gates don't open unless there's a medical diagnosis, and a plan in place that prioritises getting the patient out again as soon as possible. It's hard to get away from the conclusion that in the rush to modern medicine we've lost something important.

The same trend is visible in the care of mental health. The word 'asylum' once

connoted a place of rest and of safety, but there are now so few mental health beds available that the 'asylum' aspect of psychiatric hospital is now available solely for patients so disturbed that their lives, or the lives of others, are at risk. Earlier in the twentieth century people were often institutionalised for scandalously trivial reasons, but the pendulum has swung too far the other way and it's now impossible for me as a physician to arrange admission to psychiatric hospital on humanitarian grounds, to ease someone's suffering. The only permissible grounds for hospital admission are those of safety.

If there is somewhere safe, clean and warm to recover, no one would choose hospital over home. But the recent (and at the time of writing, ongoing) pandemic has revealed cracks in the structure of medicine, health and care, and brought many long-term problems into a short-term focus. We have the opportunity as a society to do more than simply paper over those cracks: to finally rediscover the importance of giving adequate time *and* space to convalescence.