The Total Patient-Care Approach To Chronic Disease

By JOSEPH F. FAZEKAS, M.D.

Chronic diseases are not limited to older persons. Yet, because they are, by and large, more common in older people, the care of patients with chronic disease and disability is the foremost medical problem in our aging population.

The annual frequency of disabling chronic cases among the age groups 65–74 and 75 and over is three to four times that among the population at large. Illness among the aged also lasts longer than among the population as a whole.

The real need for an organized community program to aid elderly patients who have chronic medical conditions is shown by the increasing numbers vegetating in "convalescent homes," occupying hospital beds, or simply on public assistance rolls. These people constitute a financial drain upon others as well as a great waste of potential human resources.

Since the community suffers a double loss, it has the responsibility both of preventing and of finding a remedy for the problems of chronically ill people. Admittedly, many of them cannot be restored to any kind of productive activity. Nevertheless, even more chronically ill persons are being consigned unnecessarily to a helpless existence.

The Goal of Total Patient Care

The purpose of a total program for the management of patients with chronic disabilities should be to restore them to a state of optimum usefulness in society. The problem is economic and social as well as medical. All therapeutic facilities should be available to these patients, but they may also need at least minimum financial assistance to provide for the necessities of life and for those other requirements (such as transportation to treatment areas, pharmaceuticals, and appliances) imposed by age, disease, or disability. This assistance should not be limited to indigent citizens. Persons of our so-called middle class should be qualified to receive treatment in all phases of the program without exorbitant expense. Otherwise they may forego needed rehabilitative services until it is too late.

If total patient care is to be effective, educational programs for various professional and lay groups as well as for patients must be undertaken. In our medical schools, undergraduate instruction should emphasize the importance of economic and social factors in the management of chronic diseases. Physicians would then not be completely absorbed with the diagnosis and treatment of disease entities. The public should be informed of the importance of early detection and treatment of all chronic diseases, and particularly those so frequently encountered in old age. Families must again realize that they have a certain responsibility for the care of their chronically ill members.

Moreover, all patients with a chronic disease should receive specific instructions regarding their illness, to prevent exacerbations and to delay progression as much as possible. In many cases, group educational therapy would be of great value in promoting improved self-care of patients who have the more common chronic diseases such as obesity, diabetes mellitus, peripheral vascular disease, and chronic cardiac

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disease. The community as a whole should be taught the necessity of providing for rehabilitation. Finally, industry should be informed about the excellent work potentialities of rehabilitated persons, and its fears about employing them should be allayed.

The development of an effective program for the management of chronically ill persons would require little more than the expansion and integration of existing community facilities. The total patient-care approach, however, will never be achieved unless these facilities are organized into a coordinated unit. The various health department bureaus would function more efficiently and economically if they were combined in a direct medical service unit, just as would all direct medical services if they were part of a hospital unit. With such an integrated organization, medical school curriculums could provide experience in care of patients both within the hospital proper and in all branches of medical care that the student may encounter after graduation. In addition, the practicing physician could make better use of community facilities if auxiliary services were more accessible to him. The specific needs of his patients, whether they were early case finding, continued medical supervision, occupational therapy, vocational selection, or home care, would be more efficiently satisfied. Some of these needs are discussed below as facets of a total program.

Case Finding and Selection

The identification of disease stages after the appearance of symptoms is manifestly less satisfactory than the detection of early asymptomatic cases. In the latter, hospital treatment is still unnecessary and the patient is able to earn his own way. This is particularly true of the many chronic diseases frequently found in the elderly population, and which are usually diagnosed and treated only when hospitalization becomes necessary.

Different methods of early case finding and selection have been tried throughout the country. There have been large and successful detection drives for tuberculosis, venereal disease, and diabetes mellitus. Usually these have been limited to laboratory and X-ray procedures and by no means are intended to take the place of a thorough physical examination by a physician, plus diagnostic tests.

Because of some doubt as to the efficiency of organizing separate campaigns for each disease, the concept of the "multiphasic screening line" has developed. This is designed to detect early evidence of a large number of common chronic diseases in a single short visit to a detection center. Many communities will probably establish such facilities permanently because they can be operated with a minimum of administrative expense and inconvenience to the individual.

In a total care program, definitive diagnosis of actually or potentially disabling chronic disease should be made by private physicians, by ambulatory diagnostic clinics of hospital outpatient departments, and occasionally by the hospital itself. Many patients would be referred from screening lines to these facilities for full investigation of abnormal findings, others would seek medical attention because of symptoms related to their chronic diseases or to incidental illnesses. Definitive diagnosis would disclose two large categories of incapacitating illness: those which are amenable to treatment and can be arrested, and those which are inexorably progressive. Nothing need be said here about those persons afflicted with a disease which can be completely arrested with adequate therapy before disability occurs. Patients for a total care program should be selected because of the presence of residual handicaps after arrest of a disease process or because of the probability of the appearance of varying degrees of incapacity.

Medical Care

Once a definitive diagnosis has been made, the nature of further medical attention should depend upon the patient's particular disease state, the source of his care, and his financial limitations. Uninterrupted medical supervision is absolutely necessary for the prevention or amelioration of exacerbations. The present tendency toward providing care only when exacerbations become severe enough must be reversed.

When the patient's financial status permits, medical care should be provided from the out-

set by a private physician. If the patient is indigent, out-patient clinics, held in the evening as well as in the daytime, should be available. When distance or the patient's disability makes these clinics inaccessible, the medically indigent must be transported to them or be given domiciliary care.

Rehabilitation

Many people can meet the costs of medical supervision alone; relatively few can afford to pay for the ancillary services which are so necessary for complete rehabilitation. Deprived of these facilities, people continue at their usual occupations as long as their physical condition permits. Then, depleted of their resources, they become completely dependent upon relatives or the community.

Rehabilitation efforts should supplement the medical treatment of chronic disease in such a way as to restore or maintain to the optimum degree the individual's physical and mental state and his usefulness to society and himself. Whenever possible, these efforts should anticipate the actual need and be instituted before incapacity has appeared. The physician should direct the rehabilitation program, but he cannot provide his patients with physical, occupational, and vocational therapy, find them suitable positions, or provide assistance for their dependents during the period of readjustment.

Many of the ancillary services needed by patients with chronic disease already exist in individual private organizations. Because of their cost, however, they are not all available to the average patient. The community cannot establish competitive services, neither can it afford to let its needy members suffer. The most reasonable solution to the problem would be the establishment of a community rehabilitation center to which physicians could refer patients for any ancillary services required. The center could be financed by both the community and the individual with the latter contributing a proportion of the service costs according to his financial status. It would aim, not to provide permanent care, but to enable chronically disabled patients to care for and maintain themselves as long as possible. Thus it would give the middle-income groups some protection against the prospect of inadequate support for an indefinite period. Some of the services that would be helpful to the practicing physician which could be provided in the rehabilitation center follow.

Physical Therapy

If an incapacitated person is given physical therapy, it may prevent further deterioration and restore function to such a degree that he will not have to change his occupation. When this frequently difficult change of occupation is necessary, the patient's residual physical abilities should be preserved and improved in order to provide the largest possible range of vocational choice and the basis for maximum proficiency in whatever he does.

The paucity of good physical therapy services in most communities is due to limitations of floor space in appropriate institutions, to lack of properly trained personnel, or to the high initial outlay these services require. A community health center or hospital is the logical site for the bulky and expensive equipment used in physical therapy, so necessary for the ambulatory treatment of many chronic disease patients.

Vocational Selection and Training

It is necessary to determine the patient's optimal occupation and to train him for it. His choice of work should be dictated by his physical and mental capacities, his personal preference, and the financial opportunity available in his preferred line of endeavor. In any occupational planning program, local employment needs should be constantly surveyed so that jobs selected will be important and useful.

Occupational training should be available to those patients whose age and physical disabilities require that they change jobs. In a large proportion of cases, vocational training will include occupational therapy; in all cases, its goal should be self-support. Training eventually may provide financial independence and also improve physical status by strengthening muscles, improving coordination, and increasing joint range. Where supervised graded training in selected vocations is available, there should

be sheltered workshops for the more severely disabled patients in the community center.

Laboratory Services

A well-equipped laboratory offering complete clinical studies at reasonable cost would be invaluable to the care of the middle-income, chronically ill patient. Physicians know well that much of the cost of good patient care is due to the many laboratory studies often essential for a complete diagnostic work-up. The indigent patient receives such services at community expense. The patient in the middle-income range can usually afford them during an acute illness, but their cost is prohibitive during continued control of chronic illness.

Research

Much research will be required to establish criteria by which those persons most suited for the services of a total rehabilitation program can best be selected. The cost of rehabilitation is unquestionably increased by inaccurate estimates of the work tolerance and capacity of patients with chronic disease and the time needed to help them. Inevitably, many patients are carefully treated and trained only to deteriorate, perhaps to such an extent that rehabilitation efforts fail. The community center is the logical site for research in these efforts, for the development of more efficient physiological methods which improve function, and for devising better prostheses and appliances.

Hospital Care

Hospital care is often necessary for chronic disease patients, who in fact, now occupy most of the hospital beds. Some need it because of an acute onset heralding illness, most others because of exacerbations of the disease process, or incidental accident or sickness. For still other patients, definitive diagnosis will require short initial hospitalization.

Nevertheless, making more hospital beds available to patients with chronic diseases is not the best solution of the problem. Most hospitals are still mainly geared for acute medical and surgical disturbances. Too often, for the patient with a chronic illness, they are unnecessary and expensive—in fact, nothing more than places of residence. Moreover, the inactivity and isolation imposed by a prolonged institutional existence often causes further physical and psychological deterioration. Once families and physicians have disposed of their obligations, they are often reluctant to reaccept responsibility for continued care, and the patient may find it difficult to adjust to a home atmosphere filled with resentment.

When hospitalization is specifically required, chronically ill patients may be referred to private institutions or to community hospitals. Treatment of acute medical and surgical conditions should be followed by transfer to convalescent wards, where active rehabilitation can be instituted or continued. Such facilities would greatly reduce community costs through reductions in nursing personnel and because patients could perform a large proportion of the maintenance work. Some physicians could attend acute medical and surgical cases. Other physicians could give their entire attention to the care and rehabilitation of patients convalescing from exacerbations of chronic disease. Relieved from other duties, the physician would be less likely to ignore the chronically ill patient for "the interesting case in the next bed."

Concentrated efforts toward the rehabilitation of some convalescent patients should significantly shorten their hospital stays. Once they are self-sufficient, they can be discharged to their homes and referred to the community rehabilitation center, where rehabilitative efforts can be continued.

Home Care

The home care medical program, which has been for the most part restricted to the indigent population, has been demonstrated to be of great value to both the patient and the community. It gives the patient the opportunity to remain in the family environment even though he may be totally incapacitated, thus providing the psychological drive so important for the optimum degree of recovery. It protects him, too, from the physical and emotional deterioration so frequently associated with long periods of hospital

confinement. It shifts the responsibility for his care back from the community to the family, which is often willing and able to assume the responsibility if given the necessary technical assistance.

The cost of home care for an individual patient is about one-quarter the cost of hospital care. Home care, too, leaves badly needed beds available for "acute" cases. It should not be restricted to the indigent. There is no reason why private patients cannot remain under the complete supervision of their physicians at home while receiving the ancillary services provided by home care technique.

Terminal Medical Care

There will always be patients who do not respond to rehabilitation efforts, either because of the nature of their disease or because the disease is in a terminal phase. These patients should be cared for in separate quarters if they cannot be kept at home or in supervised nursing homes.

Conclusion

The adoption of the concept of total patient care and its application to the various phases of the management of chronic disease is basic to the formulation of a chronic disease program. The success of any such program will depend upon the coordinated efforts and leadership of medical societies, medical schools, and community health officials. When the entire community is conscious of the chronic disease problem and all its existing facilities are integrated and working for total patient care, its responsibilities to patients can be more satisfactorily discharged.

Dr. Joseph W. Mountin, Pioneer in Public Health, 1891–1952

Dr. Joseph W. Mountin, Assistant Surgeon General and Chief of the Bureau of State Services of the Public Health Service, died unexpectedly April 26, 1952, at the age of 61. A Public Health Service officer for 35 years, Dr. Mountin was appointed to the post of Bureau chief November 1, 1951.

Dr. Mountin had a distinguished career with the Public Health Service and was widely known as the "father" of many Service programs.

He was a special health adviser to the Bhor Commission for the Government of India in 1947. During 1949, he was adviser on health and welfare to the Economic Mission to Colombia, South America, sponsored by the International Bank for Reconstruction and Development. At the time of his death, he was Public Health Service director of the evaluation of the 10-year health and sanitation program of the Institute of Inter-American Affairs.

The author of numerous studies and monographs on preventive medicine, public health administration, and medical care, Dr. Mountin was a diplomate of the American Board of Preventive Medicine and Public Health and a fellow of the American Medical Association. He was a fellow of the American Public Health Association and a member of its Executive Board. He was also a member of the Board of the National Organization of Public Health Nursing and had served on many official committees of other health organizations.

He was known as an authority in a wide range of public health fields from environmental health programs, such as sanitation, water pollution control and industrial hygiene, to public health nursing, public health education, the control of chronic diseases, and problems of the aging.

Dr. Mountin was born in Hartford, Wisconsin, and received his medical degree from Marquette University, Milwaukee, in 1914.

He began his career with the Public Health Service during World War I in work in extracantonment sanitation in military areas throughout the United States. He was director of the Division of Public Health Methods from 1937 to 1939 and of the States Relations Division from 1943 to 1947, when he became associate chief of the Bureau of State Services.

"Dr. Mountin was one of the real pioneers of public health in modern times. He was a man of rare gifts, of many skills, of much imagination who, throughout his long and distinguished career, provided the spark for many of the major programs of the Public Health Service and the public health movement. His wisdom, his progressive leadership, and his warm and sympathetic understanding of medical and health problems will be widely missed. His passing is a great loss to the Service and to the public health profession in the United States and throughout the world."

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