Herstel en revalidatie na hartinfarct

Summary

This thesis reports the results of two studies on recovery and rehabilitation in male patients after myocardial infarction (MI).
The first study is a national descriptive epidemiological survey on return to work of patients after MI conducted in 42 occupational health services.
The second one is a small-scale experimental study on the effects of a cardiac rehabilitation programme of the Leiden University Hospital.

Chapter one reviews the relevant literature on recovery and rehabilitation after MI. The psychosocial literature can be devided into three main approaches: the psychodynamic, health-perception and patient-career approach. After a discussion on the concepts of objective and subjective recovery, and rehabilitation, a review of the research findings is given on the effects of rehabilitation on physical, psychological and social recovery. It is concluded that research findings are scattered and rather inconclusive.

Chapter two deals with the problem-statements and designs of the studies under consideration. The longitudinal epidemiological study concentrates on a description of the rate of return to work, the interval MI - return to work, absenteeism after return and factors related to these outcome-measures. This study had follow-up measurements of six months after return to work and of twelve months after MI for those who did not return to work. The experimental study concentrates on the effects of a comprehensive rehabilitation programme with several objective and subjective outcome-measures. Rehabilitation took place between three and six months after MI. Follow-up measurements were scheduled at 12 and 24 months after MI.

Chapter three gives a description of the populations under study. In the epidemiological study, 42 occupational health services produced data on 888 patients. The possibility of underreporting by the occupational health officers is discussed. In the experimental study a group of 73 patients could be allocated at random to the rehabilitation and control group. However, since 22 patients dropped out, an

analysis on the characteristics of these patients in comparison with the remaining ones (n= 51) was carried out.
It is concluded that the internal validity of the study is not seriously threatened by the drop-outs.

Chapter four presents the main results of the epidemiological study on return to work as objective recovery. Of the 888 patients 23% died within a year after MI. In the group of survivors the rate of return to work was 65%, 37% full-time and 28% part-time return.
Probability of return proved to be optimal in the first half year after MI as 50% of the survivors returned to work in this period. Predictors (positive or negative) of return to work are in declining order of importance: age (-), angina pectoris (-), occupational level (+), cardiac complications (-), physical rehabilitation within two months after MI (+), and number of infarctions (-). Moreover, early physical rehabilitation has a positive effekt on full-time return. Occupational level (+) and angina pectoris (-) also play a role as predictor of full-time return and return to former work. Absenteeism in the group under 55 years was comparable with general Dutch figures. In patients of 55 years and older absenteeism is lower than the general figures.

In chapter five return to work is approached as a measure of subjective recovery. Firstly, the judgements of occupational health officers and patients on success of return to work is analyzed. Although both parties appear to be rather satisfied with the situation after return to work, for patients to return to their former work is more important in determining satisfaction than full-time return, while the reverse holds for the occupational health officers.
In a multiple regression analysis return to work proved to be the main determinant of life-satisfaction, also, early physical rehabilitation appeared as a positive predictor of satisfaction.

In chapter six the main results of the experimental study are presented. The outcome measures of 6, 12 and 24 months after MI were: maximal exercise tolerance, degree of activity, subjective load, perceived exercise tolerance, participation in household labor, leisure activities, daily use of time and optimisme about future health. With theexception

of a short-term training-effect in the rehabilitation group (n= 24), no further differences between this group and the control-group (n= 27) could be found. There were, however. indications that spouses in the rehabilitation group were positively influenced by the programme. In the discussion much attention is given to the fact that on all measurements the control-group turned out to be slightly, though not significantly, better than the rehabilitation-group. This and the indications that the late start of the programme (3 months after MI) might have disturbed social recovery are presented as explanations for the failure of the assumed rehabilitation effects to materialize.

Chapter 7 starts with an analysis on the possible interaction between return to work and rehabilitation. It is concluded that no such interaction is apparent. Analogous with the epidemiological study the factors predicting return to work are considered. It appears that compartmentalisation, based on low neuroticism and high extroversion scores, is a coping strategy with a favorable outcome on return to work. It was not possible to include coping strategy in a path-analysis on return to work due to curvilinear relationships. The model developed includes the main variables of the epi-demiological study: age, occupational level and angina pectoris, plus subjective load, perceived exercise tolerance and maximal exercise tolerance at three months after MI. It appeared that with the exception of age, health perception variables intervene between the background variables and return to work.

Chapter eight summarizes the most significant results and discusses theoretical and practical implications of the two studies. Return to work appears to have a certain value as an outcome measure for recovery and rehabilitation. This, however, is confounded by the fact that present socioeconomic circumstances exert a negative influence on return to work. More attention should be qive to the definition of additional social outcome measures after that it is possible to develop rehabilitation programmes which are tailored to individual needs and goals.