A study of the adjustment of patients discharged from the Jefferson Tuberculosis Sanatorium between November, 1945, and November, 1946

Mildred Young

Atlanta University

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A STUDY OF THE ADJUSTMENT OF PATIENTS DISCHARGED FROM
THE JEFFERSON TUBERCULOSIS SANATORIUM BETWEEN
NOVEMBER, 1945, AND NOVEMBER, 1946

A THESIS
SUBMITTED TO THE FACULTY OF THE ATLANTA UNIVERSITY SCHOOL OF
SOCIAL WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
MILDRED YOUNG

ATLANTA, GEORGIA
JUNE 1948
Acknowledgments

The writer wishes to express her deep indebtedness to the many persons who made this study possible. Among them are Mrs. Margretta Hubbard, Medical Secretary of the Jefferson Tuberculosis Sanatorium, Miss Kathryn Fowlkes, Medical Social Worker of the Jefferson County Board of Health, the Public Health Nurses and others.
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CHAPTER I

INTRODUCTION

Statement of Problem

Notable progress has been made in the fight against tuberculosis. Today doctors are well equipped with dependable means of detecting tuberculosis when it exists. They know how to treat the disease once it is discovered. In most parts of the country the public authorities have provided or are planning to erect hospitals to care for the patients.

Tuberculosis now claims about one-third as many victims as it did even so recently as twenty years ago. However, the development of an equally adequate rehabilitation program lags far behind that of treatment and case-finding. The period of adjustment after sanatorium discharge is of extreme importance in the defense against the disease.

Many patients who are discharged from tuberculosis sanatoria die or suffer a recurrence of the disease within twelve to eighteen months following discharge. Many are unable to endure the stresses and strain of resuming the daily routine of life. These persons have a physical handicap engendered by the disease process itself and by the inactivity which is so great a part of the treatment. The physical handicap is not all. They are mentally insecure because of the hazard of recurrence of illness. Many have economic and family problems that aggravate the condition. It is not uncommon for the same patient to return to the sanatorium three, four

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and five times. Such experience is not only the cause of despair for the patient, but the public health hazard and the economic cost are very great.1

People who have had tuberculosis need better care and more rest than those who have never had the disease. They have a handicap that cannot be safely forgotten. A recovered patient is able to work or play, but not to do both.2 If sanatorium graduates take care of themselves and the family sees to it that they have the needed rest and they live according to the rules learned in the sanatorium, they should continue to look and feel well.

Purpose of Study

This study has been undertaken in order to discover what effect social, emotional and economic factors have had on the adjustment of the discharged sanatorium patient; and how these forces may have affected his medical treatment, and his attitude and that of his family towards the illness.

If, in light of the findings, there is need for more attention to problems of readjustment and rehabilitation of patients served by the sanatorium, the writer plans to suggest possible next steps.

Scope and Limitations

This study is limited to Negro patients discharged as arrested, quiescent or improved from the Jefferson Tuberculosis Sanatorium, Birmingham, Alabama between November, 1945 and November, 1946. This period was chosen because the study was begun in November, 1947 and the discharged


2State of Georgia Department of Public Health, What You Should Know About Tuberculosis (Atlanta, Georgia, 1938), p. 29.
patients had an adjustment period of from one to two years. The agency suggested that those patients who were discharged from the sanatorium against medical advice be excluded from the study because they did not receive the full benefit of medical treatment.

Only sixteen Negro patients were discharged from the sanatorium with medical approval within the period chosen. One of these patients was discharged after a change in the diagnosis from tuberculosis to breast cancer. Therefore the study is limited to fifteen patients.

It was thought that a larger group of patients would yield more valuable conclusions, and consideration was given to including patients discharged during the previous year. However, several obstacles stood in the way of carrying out this idea, the most important being the limit of time.

The fifteen patients studied comprise only about one-fourth of the Negro patients discharged from the sanatorium during that year. Many patients left against medical advice. An investigation of this problem might well result in a valuable study.

Method of Procedure

A schedule was devised for tabulation of data. Identifying information was secured from the records at the sanatorium and the records of the Tuberculosis Registry. As social histories were not included in the sanatorium records of patients at that time, interviews were held with Public Health Nurses to whom the patients were known. The Public Health Nurse was especially helpful in evaluating the patient's condition because she always had at her disposal the latest clinic report concerning the patient and she made regular visits to the home. Finally, interviews were
held in the homes with the patients and their families. In most instances the Public Health Nurse accompanied the writer to the home of the patient and made the instructions. In other instances, the nurse made appointments with the patients for interviews.

For source material various books, magazines and pamphlets were consulted. (See Bibliography)
CHAPTER II

WHAT IT MEANS TO HAVE TUBERCULOSIS

Incidence of Tuberculosis

No age is exempt from tuberculosis. The disease is met within the infant and in the octogenarian. It is being increasingly noted that tuberculosis is highly fatal to persons who have passed sixty-five.¹

In 1945 there were 52,916 deaths from tuberculosis. A large number of these occurred in the large cities.² This does not account for the persons who are ill with the disease.

No accurate figures are available for the morbidity of the disease. It is estimated that in many communities about one-third of the population has active tuberculosis and one percent has arrested disease. There are approximately nine active cases for each death per annum.... Morbidity decrease has not kept pace with mortality decrease.... It is the chief cause of disability and death in man's most productive period, 20 to 35.³

In an article in the Social Work Yearbook, Charles E. Lyght discusses the racial factor and tuberculosis:

Among Negroes the tuberculosis death rate is three and one-half times that among whites, while the mortality rate in Spanish-speaking groups and American Indians is several times that of the general population. These findings are not traceable to any specific inability to withstand tuberculosis, but to the multiplied chances for


²Ibid., p. 6.

infection and the poorer opportunities for recovery that exist in the presence of low income, inadequate education, overcrowding, deficient nutrition and unhygienic surroundings.\(^1\)

In 1945 tuberculosis was the chief cause of death among non-whites between the ages of fifteen to twenty-four. Among non-white females of this age group tuberculosis accounted for one-half of all deaths and among males one-third.\(^2\)

Tuberculosis is not a hereditary disease, but it is known to run in families because of the close contact of family living. It thrives best when unsuspected cases live closely and over prolonged periods with unwary contacts.

Prevention and Control

Case-finding programs are the most effective means of preventing and controlling tuberculosis through mass and individual examinations for the purpose of locating unsuspected tuberculosis. Since Pearl Harbor, nearly 750,000 war workers and their families have been X-rayed through mass surveys conducted by the United States Public Health Service in cooperation with local health departments and tuberculosis associations. Many of these persons were found to be unsuspecting victims of tuberculosis.\(^3\)

At the present time there are two case-finding methods: the radiographic studies of cross sections of the population and epidemiological surveys. The former type includes a variety of groups—social, industrial,


\(^2\) Sara A. Lewis and Richard V. Kasius, \textit{op. cit.}, p. 5.

\(^3\) Charles E. Lyght, \textit{op. cit.}, p. 460.
racial, age and geographical. The latter group includes contacts of previously diagnosed cases of tuberculosis.¹

Many hospitals are now participating in the tuberculosis control program by requiring that each patient entering the hospital be X-rayed upon admittance. Among many of the people who are admitted to hospitals are found victims of tuberculosis. These are the unsuspected cases that spread the disease. Sixteen million persons are admitted to hospitals every year, constituting the largest single source of those adults among whom the disease is most prevalent. They offer the hospital staff the opportunity to protect the community against spreaders of tuberculosis and the chance to save lives of many who, if allowed to continue without treatment, would advance too far into the disease to be saved.²

In order to improve the administration of the tuberculosis control programs central tuberculosis case registers are being established in many communities. This makes available information concerning all known cases of the disease, in addition to information concerning tuberculosis contacts.

Experiences of the United States and the Scandinavian countries point the way and leave no doubt that the concentration of many men and agencies in all aspects of tuberculosis control can defeat a disease that takes a greater toll of lives than does the most disastrous war.³

¹United States Public Health Service, Medical Social Service in Tuberculosis Control, Government Printing Office, 1946, p. 3.


Symptoms and Signs of Tuberculosis

Pulmonary tuberculosis (tuberculosis of the lungs) is the most common form of the disease. In its early stages, the disease is often asymptomatic. There may be unusual fatigue at the day's close, slight loss of weight, an accelerated pulse or a pain in the chest, but these manifestations are seldom noticed. Later, the victim becomes aware of fever, night sweats and chills. There may be a slight cough, chronic hoarseness or indigestion. Soon a little streaking of the sputum may be observed.

In making a definite diagnosis, the physician may first give a tuberculin test which will determine whether the patient has been infected with tuberculosis. This is commonly called the skin test. By this method, a small amount of tuberculin is applied to the skin, and if there are germs in the body, a raised red area will result in two or three days.

The next step is X-ray. At this point it is determined how much tuberculosis the person has and how active the disease is. If there are suspicious shadows on the X-ray film, a sputum test may be recommended in order to definitely establish or rule out the diagnosis.

Methods of Treatment

Rest is the cardinal therapeutic in the treatment for tuberculosis,¹ and is sometimes all that is needed for the treatment of the early stages of the disease. Sometimes general rest is not enough, the affected lung may need rest. This may be done by various surgical methods. One of the most widely used operations is pneumothorax in which air is induced

between the layers of the pleura, placing a cushion of air around the lung which causes it to occupy a smaller space. This lessens the movement of the lung and gives it a chance to heal.

Thoracoplasty is an operation designed to give rest to the lung by removal of the ribs over the diseased area, permitting the muscles and other structures in that area to fall inward, thus relaxing the diseased part of the lung. New ribs will grow in about three months and in such a way as to leave the diseased area permanently collapsed.

Phrenic nerve paralysis is another surgical procedure for giving rest to the lung. This operation stops the action of the phrenic nerve which controls the diaphragm, a powerful muscle that moves up and down with breathing. Halting the action of the diaphragm saves the lung much motion.

Other surgical procedures include pneumolysis, an operation which makes pneumothorax more effective by the cutting of adhesions that hold the lung to the chest wall; lobectomy, the removal of part of a lung; pneumonectomy, the removal of one whole lung; and pneumoperitoneum, introduction of air into the abdominal cavity to push up the diaphragm.

Recently there has been widespread publicity concerning the use of chemotherapeutic agents in the treatment of tuberculosis. The drug most loudly acclaimed is streptomycin. In 1946 at the Mayo Clinic streptomycin was used and found to be effective in certain types of tuberculosis. However, the use of streptomycin is still in the experimental stages and further investigation is needed before its use can be generally accepted.

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Charles E. Lyght states that "no drug has been found that can be both safely and effectively employed although encouraging results are sometimes reported."¹ Another writer declares that the drug cannot be substituted for control work carried by accepted methods.²

Along with each method of treatment, it is necessary for the patient to have nourishing food, fresh air, and plenty of sleep. The best place for effective treatment of tuberculosis is the sanatorium, which is the only place where complete rest is possible. There the patient has the advantage of specially trained nurses and physicians. Well-balanced meals are planned to build up the body and its powers of resistance. The patient is protected from thoughtless visitors who might interrupt and prevent rest.

**Emotional, Social and Economic Implications**

It is an accepted fact that tuberculosis is one of the diseases in which body and mind must be treated simultaneously in order to insure the most effective results.

Numerous problems——social, economic and emotional are occasioned or intensified by a diagnosis of tuberculosis. Emotionally the patient may be greatly frightened and anxious concerning the outcome of his disease, the possibility of death, the possibility of surgical treatment; the danger of becoming physically, economically and emotionally impotent and

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dependent; being stigmatized, and the realization that others in the family might have become infected. Patients seem unable to accept the prescribed medical regime which means restricted activity and removal from all close associates.

Being isolated from family and friends means not only being separated from loved ones and the privilege of actively engaging in human affairs, but also to some it implies a stigma...a feeling of being unwanted or taboo.¹

Among other fears of the tuberculous patient are those with social implications involving loss of status in the home and community as a wage earner, marital infidelity, and the complicated problem of sexual relationships including the possible inadvisability of having children.

These emotional and social problems may be complicated by well-intentioned but ignorant and superstitious friends and relatives. Problems may arise from the attitudes of the patient's family. There may be a fear of the disease and a lack of understanding of the patient's needs and limitations.

Economic needs are one of the major causative factors in the emotional distress. Family resources are often exhausted during a long illness, especially when the major wage earner is involved. This may lead to a request for financial assistance from community agencies. It is extremely important that economic and financial problems be settled in order that the patient's family can survive, and in order that the patient may have

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a satisfactory environment to which he can return with no danger of reinfection or the possibility of breakdown.

The medical social worker can make great use of her skill in handling these problems. Generally, the major function of the medical social worker will be to discover, evaluate, and assist in the solution of the emotional, social, and economic factors which hinder the patient in adjusting to his medical problem.¹

The problems which will require her greatest skill are those with emotional implications. Social and economic problems are more easily treated because they are less subtle and more tangible. The adequacy of handling them depends upon community and family resources.

CHAPTER III

MEDICAL AND SOCIAL SERVICES FOR THE TUBERCULOUS PATIENT OF JEFFERSON COUNTY

Besides the services and facilities of the Jefferson Tuberculosis Sanatorium, the tuberculous patient of Jefferson County is under the direct surveillance of the Jefferson County Health Department which administers health centers in various sections of the county in a decentralized system. The Health Department employs Public Health Nurses who are stationed at the centers.

The Jefferson Tuberculosis Sanatorium

The Jefferson Tuberculosis Sanatorium is located within the city limits of Birmingham, Alabama on one of the beautiful mountains overlooking the city.

At present the sanatorium has a capacity of 225 beds which are about equally divided between the separate buildings for Negro and white patients. The building for Negro patients was erected in 1937 and is considered modern and well-equipped.

The sanatorium is supported by funds from the city of Birmingham, Jefferson County, and the state of Alabama.

The staff of the sanatorium is divided into three groups, administrative, medical and consultant. The administrative staff consists of the Medical Director, Business Manager, Supervisor of Nurses, Operating Room Supervisor, Medical Secretary and Office Supervisor.

The Medical Staff includes the Chief of Staff and the Chief Surgeon. As the sanatorium works in direct-cooperation with the Medical School of
the University of Alabama, there are two medical students available each month to augment the medical staff. The Consultant Staff consists of visiting physicians from the medical school and they are specialists in other fields of medicine.

The sanatorium's 225 bed capacity is only of recent development. In the staff's 1947 report to the Board of Directors it was brought out that during the previous year the bed capacity had been increased from 125 by remodelling and better utilization of space.1 Nevertheless, the sanatorium is still unable to accommodate all patients in need of sanatorium care, and often a patient must wait months after application before he can be admitted.

In 1946 the staff method of determining treatment was inaugurated. By this method the opinions of several chest specialists are coordinated into a single decision which determines the treatment for each patient and which is modified or changed only on subsequent staff discussions or emergencies. The Medical Director retains the right of final decision and responsibility.

The Health Centers

In conveniently located sections of Jefferson County are health centers which hold various clinics. Besides serving tuberculous patients, the centers hold pediatric, maternity, child-spacing and venereal disease clinics. Dental services are available to pre-natal patients and children.

1J. G. Bohorfoush, "Report to the Board of Directors of the Jefferson Tuberculosis Sanatorium" (Birmingham, Alabama, 1947), p. 3 (Mimeographed.)
The tuberculosis patient is usually referred to the clinic for diagnosis and recommendations. The referrals are made by private physicians, Public Health Nurses or the Birmingham Tuberculosis Association. The latter organization conducts mass case-finding programs by means of X-ray examinations on mobile buses. If an X-ray proves suspicious, the patient is sent to the clinic for further observation.

Treatment is available at the health centers for certain patients. These include those patients who have been discharged from the sanatorium with recommendations for continued pneumothorax and those who are being cared for in the home. The discharged sanatorium patients also come to the centers for periodic examinations. The family contacts of these are also followed and kept under examination and observation at the clinics.

The Public Health Nurses

In addition to referring tuberculous patients to the health centers for diagnosis and recommendations, which is actually a case-finding function, the Public Health Nurse renders direct service to patients discharged from the sanatorium, those awaiting entrance into the sanatorium and those who must be treated at home. Her responsibility, which is described by Dorothy Deming in a pamphlet for nurses, "is to give nursing care and health teaching in the home under medical directions."1

If there are social problems, the Public Health Nurse makes referrals to Medical Social Service. In many instances, because of the limitations of medical social service, the Public Health Nurse makes a

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1Dorothy Deming, "Pointers for Nurses," Home Care of Tuberculosis, National Tuberculosis Association (New York, 1943), p. 5.
direct referral of special problems to agencies in the community which are equipped to meet them. During 1947 the Public Health Nurse was asked to assist medical social service in preparing social histories on all applicants for admission to the sanatorium.

Medical Social Services

Medical social service is under the general administration of the Bureau of Child Hygiene and Public Health Nursing. It is not a separate department, however, actual supervision stems from the Medical Social Consultant. The medical social service staff of two persons gives case work services to individual patients and acts in a consultative capacity to the Public Health Nurses.

Recently an emphasis has been placed on the work of medical social service. All newly diagnosed tubercular patients are referred to the social worker in the health centers if there is one available. The medical social worker assists the doctor and the Public Health Nurse in obtaining a better understanding of the patient as a person in order that a well-rounded treatment plan might be made. There are numerous social problems that are dealt with by the medical social worker such as financial problems, poor housing, broken homes, care of children, marital difficulties and resistance to medical recommendations. In instances where the patient refused sanatorium care it was the best plan for the doctor, Public Health Nurse and social worker to review the total situation in order to determine the next step.

1"Social Service Report" (Birmingham, Alabama, Jefferson County Health Department, 1947), p. 4 (Mimeographed.)
During 1947 social histories were prepared on all applicants for the sanatorium. In centers where there is a social worker the social histories were prepared cooperatively with the Public Health Nurse.

A social worker from the Health Department spends one day a week at the sanatorium in an effort to help with the patient's individual and family problems. In some cases the worker has been able to prevent patients from leaving the sanatorium against medical advice because she was able to assist the patient in working out his problems.

Because of the limitations of the staff of medical social workers all patients cannot be given this service. At present the entire staff consists of only two persons, the Medical Social Consultant and a Medical Social Worker.

The present Medical Social Consultant is a graduate of Tulane University School of Social Work. She acts in a supervisory capacity and gives both direct and consultant services.

The other Medical Social Worker is a graduate of Simmons College School of Social Work, Boston, Massachusetts. At the time of this study she was stationed at Western Clinic where she gave direct services to patients, and it was at this center that the writer had a field work placement.
CHAPTER IV

GENERAL CHARACTERISTICS OF PATIENTS

In considering the characteristics of the fifteen patients included in this study, it is advisable to keep in mind those factors which have definite bearing on the problem of tuberculosis. Among them are age, sex, economic conditions, type of community and employment experience.

Age and Sex

Sara A. Lewis and Richard V. Kasius report that age and sex were important factors affecting the mortality rates for tuberculosis in 1945. It was of greater importance as a cause of death among Negro females at the younger ages.¹

As shown in Table 1, thirteen of the patients studied were females. Six of them were between the ages of fifteen and twenty-five. Five were between the ages of thirty and thirty-five. The two male patients were both under thirty.

<table>
<thead>
<tr>
<th>AGES</th>
<th>TOTAL</th>
<th>MALE</th>
<th>FEMALE</th>
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<tbody>
<tr>
<td>Total</td>
<td>15</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>15-19</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20-24</td>
<td>4</td>
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<td>4</td>
</tr>
<tr>
<td>25-29</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>30-34</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>35-39</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>40-44</td>
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<tr>
<td>45-49</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
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</table>

¹On. cit., p. 3.
Religious Affiliation

Only one patient had no religious affiliation. Of the other fourteen, twelve were Protestant and two Catholic. Eight of the Protestant patients were members of the Baptist denomination; three were Methodists, and one a member of the Sanctified Apostolic Holiness Church.

Table 3 shows the religious affiliation of the fifteen patients studied.

**TABLE 3**

**RELIGIOUS AFFILIATION OF FIFTEEN PATIENTS DISCHARGED FROM JEFFERSON TUBERCULOSIS SANATORIUM**

<table>
<thead>
<tr>
<th>CHURCH</th>
<th>TOTAL</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Methodist</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Catholic</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Holiness</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Housing Situation

There is evidence of direct relationship between poor housing and poor health. Much of the evidence is based upon European experience pertaining to the reduction in mortality associated with the re-housing of poor families living in antiquated dwellings in run-down neighborhoods. Death rates were invariably higher where there were impure water supplies, insanitary toilets, lack of private toilets, overcrowding, inadequate light and ventilation.¹

Among the fifteen patients there were some with housing conditions such as those described above. Two examples of such situations are cited below:

Case 4

Mrs. G., aged thirty-one and mother of four, lived in a three room house with her husband and children. The youngest child, aged one and one-half years, slept in a crib in the same room with the patient and her husband. There was only one window in this room. (Case 4 will be discussed again in another chapter)

Case 13

This patient, a fifteen year old girl, lived in a two room house with her mother, brother, grandmother and aunt. The patient slept in the only bedroom with her mother. Another bed in this room was occupied by her grandmother and aunt. The brother slept on a cot in the kitchen. This family's two rooms were part of a duplex building, and a family of four lived on the other side. Both households used the same outdoor toilet and outdoor hydrant.

Four of the patients slept in the living rooms of their homes, but these rooms were constantly in use by the other members of the family for entertaining and studying, and were usually located in such a position that no other room in the house could be reached without passing through.

If we accept the theory that in housing the standard for decency is one person per room, four patients had satisfactory housing.

Case 11

Mr. L., a veteran, aged twenty-nine, lived in a five room house with three other adults. The patient had a pleasant and sunny room that was set apart from the rest of the house.

Ibid., p. 80.
However, accepting the general standard for housing does not always give an adequate picture of the situation as is shown in the following case.

Case 15

Miss W., a young woman of twenty, had her own room, which had been built especially for her. However, there was no heat facility for winter, so the patient slept on the sofa in the living room part of the time.

Economic Status

It is universally conceded that low economic status is one of the major handicaps which the Negro has to carry in his fight against tuberculosis.¹ Eight of the patients studied were being assisted by the Department of Public Welfare. They were receiving less than fifty per cent of the minimum budgetary needs because of the shortage in the agency's funds. It was necessary for some supplementation of this small amount. All of the patients received checks ranging from twelve to twenty dollars a month, which was supplemented by some member of the family. Two illustrations are given below:

Case 7

Miss H., aged twenty, received a monthly check of fifteen dollars from the Department of Public Welfare. The patient's mother assumed responsibility for the remainder of the home expenses on her earnings of fifteen dollars a week as a maid. The stepfather had been unable to work for several months because of a chronic illness.

Case 8

Mrs. J., received twenty dollars a month from the Department of Public Welfare. Her husband had contracted tuberculosis during her illness and had to go to a sanatorium. The patient's son, a high school boy, worked in the evenings after school and on Saturday earning fifteen dollars a week. The son’s earnings were an important part of the income.

Three of the patients were adequately supported by their husbands on earnings ranging from forty to fifty dollars a week. For example:

Case 9

Mrs. M.'s husband, a coal miner, earned approximately fifty dollars per week. These earnings were sufficient to meet the needs of the family which included two small children. Recently, the husband had completed payments on their nicely furnished three room house.

Three patients were supported by their fathers, but the incomes were barely sufficient to meet the needs of the patients and the others in the home. One example is cited below:

Case 3

The patient, a young girl of seventeen, was supported by her father, a coal miner, who earned thirty dollars a week. This was the only income for the family of three adults and four children. The patient's diet was not adequate, but she was not eligible for assistance because her father's earnings far exceeded the budget of the Department of Public Welfare for a family of that size.

Occupations Prior to Admission

Tuberculosis is not caused by work, but always by the tuberculosis germ. The important factor is overfatigue or conditions of work that
lower resistance to all disease.\textsuperscript{1}

\textbf{TABLE 4}

\textbf{PREVIOUS OCCUPATION OF FIFTEEN PATIENTS DISCHARGED FROM JEFFERSON TUBERCULOSIS SANATORIUM}

<table>
<thead>
<tr>
<th>OCCUPATIONS</th>
<th>TOTAL</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>In school</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cook</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Laundress</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maid</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Army</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4 shows the employment status of the patients prior to illness. Three patients had no previous employment when they became ill. However, each was a busy housewife and the mother of young children. They all had the common complaint of overfatigue before they went to the sanatorium.

Five patients, one male and four females, had been in school prior to illness, and they had no previous employment experience. One patient had been in the army where he was assigned to the Engineering Corps.

Five patients had been domestics before they became ill; another had been a laundress. The latter patient was very emphatic in her belief that her condition had been caused by laundry work.

\textbf{Type of Community}

Density of population is considered an important factor in regards to tuberculosis. Studies have shown that mortality rates are higher in urban areas.

\textsuperscript{1}Dorothy Deming, \textit{op. cit.}, p. 27.
communities and the incidence is greater. This might be due to the close-
ness of personal contact in cities or it might have entirely different 
significance. "In considering the data in the tuberculosis mortality for 
residents of large cities and smaller communities, differences in the use 
of medical facilities may increase the accuracy and frequency of diagno-
sis."¹

Ten of the fifteen patients lived in urban communities. Many lived 
near factories, railroads and other industrial sites. The homes were 
usually built close to each other on narrow unpaved streets that were 
densely populated. The remaining five patients lived in rural communities.

¹Sara A. Lewis and Richard V. Kasius, op. cit., p. 16.
CHAPTER V

MEDICAL FACTORS INVOLVED

Medical Diagnosis upon Admission to the Sanatorium

Tubercular patient who are treated at the Jefferson Tuberculosis Sanatorium are classified to conform with the present day diagnostic standards of the National Tuberculosis Association. Thus, upon entrance, the stage of the disease may be designated as minimal, moderately advanced or far advanced tuberculosis. These diagnoses are very important in deciding the length and type of treatment the patient will receive. A patient who has far advanced tuberculosis is a more serious medical problem than the one who has minimal tuberculosis. In minimal cases a complete bed rest regime is often all that is recommended, whereas in the other two stages surgery may be indicated.

TABLE 5

MEDICAL DIAGNOSES OF FIFTEEN PATIENTS UPON ADMITTANCE TO JEFFERSON TUBERCULOSIS SANATORIUM

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>TOTAL</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Tuberculosis</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Moderately Advanced</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Far Advanced</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5 shows the diagnoses of the fifteen patients studied. Four patients had minimal tuberculosis, four had far advanced, and seven had moderately advanced tuberculosis. Later discussion will reveal that the
majority of the problems of adjustment arose among those patients with severe cases.

Clinical Status of Disease at Dismissal

When patients are dismissed from the sanatorium, the clinical status of the disease is usually designated as arrested, quiescent, improved or unimproved tuberculosis.

Arrested pulmonary tuberculosis indicates that constitutional symptoms are absent and the chest lesion has been healed for six months, during the last two of which the patient has been taking one hour's walking exercise twice daily or its equivalent. Tubercle bacilli are not in the sputum. If the disease is quiescent, no constitutional symptoms are present but the sputum may contain the tubercle bacilli. The lung shows healing that has existed for two months. In improved tuberculosis the symptoms may be present, but X-ray films indicate healing has begun. If the condition is unimproved, the symptoms may be unchanged or worse.¹

Among the seven patients who had moderately advanced tuberculosis, six were discharged as improved and one as quiescent. One of the far advanced cases was discharged as unimproved, one as quiescent and two as improved. Among the four minimal cases of tuberculosis, one patient was discharged as an arrested case and the other three as quiescent.

Methods of Treatment

Jefferson Tuberculosis Sanatorium has excellent facilities for surgery. In a report for 1946, it was disclosed that there were nine

phrenic nerve operations, 36 thoracoplasties, 80 pneumolysis operations and 4,428 pneumothoracies.¹

There were two types of surgery performed on the patients of this study. Two of the far advanced cases received pneumothorax operations, along with four of the moderately advanced cases. One moderately advanced case received pneumothorax with pneumolysis.

The remaining eight patients were placed upon complete bed rest during their entire stay in the sanatorium. Two of these patients were far advanced cases, one of whom was discharged as unimproved and the other as quiescent.

**TABLE 6**

**LENGTH OF TIME SPENT BY FIFTEEN PATIENTS IN JEFFERSON TUBERCULOSIS SANATORIUM**

<table>
<thead>
<tr>
<th>NUMBER OF MONTHS</th>
<th>NUMBER OF PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>3</td>
</tr>
<tr>
<td>4-6</td>
<td>1</td>
</tr>
<tr>
<td>7-9</td>
<td>3</td>
</tr>
<tr>
<td>10-12</td>
<td>5</td>
</tr>
<tr>
<td>13 or more</td>
<td>3</td>
</tr>
</tbody>
</table>

**Length of Stay in the Sanatorium**

During the period considered there was a general policy of limiting patients to one year in the sanatorium because of the lack of adequate space for serving them longer. That this policy was not rigidly adhered

A discharged tuberculosis patient must make an adjustment to his medical-social situation if he is to achieve maximum happiness, and if he is to avoid reactivation of his disease. This is true whether the patient is discharged as an arrested, quiescent or improved case. "Chronic illnesses create a way of living." The person who has had tuberculosis must modify his vocational and recreational interests, and must keep constant watch over his health. The ability to do this depends to a great extent upon the patient's emotional endowments and his social situation. "It is recognized by the medical profession that the mind plays an important and perhaps a major role in aggravating early tuberculosis, fostering its progress and acting as an adversary to recovery." It is safe to go further and state that the mind plays a major role in preventing satisfactory adjustment. The person who has had tuberculosis has many fears and anxieties. 

No less important is the social situation to which the disahergee from the sanatorium must return. All illnesses create or aggravate social and emotional problems, and "too often medical care is wasted because of some such unsolved difficulty." Practical reality problems such as financial


need, marital discord and unemployment must be dealt with.

Ideally, all cases ready for discharge from the sanatorium should receive a social as well as a medical review. This is important to the patient, his family and the community, if all are to be protected. Because of the limitations of the medical-social services available to the patients of the Jefferson Tuberculosis Sanatorium, a social review is impossible except in a few cases that are specially referred for such service by the doctor or nurse. Four of the patients of this study who were receiving medical social services after discharge will be discussed.

At the time of this study, the fifteen patients had been discharged for a period of between one and two years. Seven had been away from the sanatorium between one year and eighteen months, and the remainder between eighteen months and two years.

Medical Follow-Up

In keeping with the recommendations of the physicians, thirteen of the patients were regular in reporting to the clinics for subsequent observation. Three of these were receiving pneumothorax. One, a veteran, went directly to the sanatorium for treatment. Although this patient's disease was far advanced, he was making a remarkable adjustment. Unlike many veterans, tired of control and authority, he accepted a rigidly ordered life such as he encountered in the army.

Two patients had discontinued follow-up care. Short summaries of these cases follow.

Case 4

Mrs. G., the thirty-one year old mother of four children, had been diagnosed as having far advanced tuberculosis. The
patient was extremely disturbed by the diagnosis and expressed fear of dying. After one year in the sanatorium, she was discharged as unimproved. After discharge she returned to the clinic one time for examination and was told that her condition was no worse. This news seemed to have given the patient the feeling that medical care wasn’t necessary, therefore, she has not returned for another examination. In spite of the efforts of the Public Health Nurse and the medical social worker, she has also refused to allow her children to be examined. In addition to this, the patient has not followed instructions for the protection of her family from infection. Whether or not the children and husband have become infected is not known. In all contacts, the patient showed an extreme reluctance to discuss her illness.

"A healthy adjustment means a psychological awareness and acceptance of illness."\(^1\) Apparently, Mrs. G. had found her diagnosis so traumatizing that she had an emotional need to suppress all reminders of her illness. This attitude was seriously endangering her own health and that of her family. The medical social worker is still working with this patient for the purpose of modifying her attitude and helping her to become more cooperative in the interest of her family.

Another patient’s problem, though in no way connected with her illness, had direct bearing on her attitude and interest in continuing medical follow-up:

Case 5

Mrs. C., mother of five children, contracted minimal tuberculosis and was admitted to the sanatorium so that she could have complete rest and also safeguard the health of her children. After a short hospitalization, during which time her children were cared for by relatives, the patient was discharged. Her condition showed continued improvement, and at first she was very cooperative in returning for clinic check-ups. Recently, however, the patient has shown a marked loss of interest in

\(^1\)Bessie Schless, *op. cit.*, p. 322.
her medical condition which has been attributed to the death of her oldest son who was shot by a policeman.

Recreational and Social Adjustment

Most of the patients recognized the importance of moderation in recreational activities, although several complained of boredom. Six named the movies as their chief form of diversion, three listened to the radio, and one spent a great deal of time reading. Two patients engaged in light sports and went to parties occasionally. One patient played cards with a group of friends. Only two patients insisted that they had absolutely no recreation.

"There is a social stigma surrounding tuberculosis based upon the fear of infection and the belief that tuberculosis is a disease of poverty and degradation." Whether any of the patients really felt stigmatized was not actually expressed although the majority of them stated that they did very little visiting and had few callers. One patient thought her friends were unchanged in their attitudes, while others said that they had never had many friends. One patient expressed her feelings about her social status as follows:

Case 2

Mrs. C., who had moderately advanced tuberculosis, had been discharged from the sanatorium as improved. In discussing the attitudes of her friends, she said casually that they all "must think I am poison or something, because they cover their mouths when I talk to them." The patient is a member of the Apostolic Holiness Church which she attends regularly. This happens to be a religious sect that believes in divine healing to a great extent.

1Ruth Cowell, op. cit., p. 100.
Although church attendance was not suggested to the patients as a form of recreation, it was significant that the majority of the patients obtained much satisfaction from their churches.

Type of Work Since Discharge

The one patient who was given medical permission to engage in some form of light work was not employed because of her inability to secure work suited to her limitations. The medical social worker was working with this patient and attempting to help her in obtaining an increase in grant from the Department of Public Welfare.

One patient, a former school girl, had found satisfactory employment. She did not wish to return to school because her class had left her behind. Another patient, who might have returned to school, was kept at home by her mother who had become extremely protective of her after the death of an older son from tuberculosis.

Among the other patients there were several who were kept busy with household tasks, but most were careful in observing rest periods.

Family Relationships

The families of the majority of the patients were able to accept the limitation of the ill persons. One patient, a young wife and mother, was fortunate to have a husband who was resourceful and understanding. His attitude reduced this patient's problems to a minimum.

Two other patients had marital problems which resulted in some difficulties. Whether or not these problems existed prior to illness is not known. Brief summaries of these cases follow:
Case 15

When Mrs. W. became ill with far advanced tuberculosis, her husband left her immediately. After twelve months, she was discharged from the sanatorium and began living in her brother's home. However, she was extremely restless and insisted on trying to work in a laundry where she had worked before her illness. She worked there two months and became ill again. Recent clinic reports indicate that the patient will probably need rehospitalization. The brother, disgusted at patient because he feels that she has not taken care of herself, has threatened not to visit her in the sanatorium. This has caused her much anxiety. The medical social worker is working with this patient in trying to help her overcome her anxieties and also to regard health measures which the doctor has recommended.

Case 8

During Mrs. L.'s hospitalization of thirteen months, her husband became interested in another woman. After the patient's return there passed several months of marital friction. Then it was found that the husband had contracted tuberculosis, and he was sent to the sanatorium. Mrs. L. was left uncertain of her husband's true feeling towards her. She wonders whether there will be a reconciliation when he returns home.

Both cases cited above illustrate the importance of a favorable and understanding attitude on the part of others in the family. These patients apparently have a strong need for love and protection. Many have deep feelings of rejection and often become unreasonable and demanding.1

Other Adjustment Problems

"Each patient suffering from long term illness has the right to be known as an individual with hopes, fears and aspirations for himself."2 Several patients were going forward in working out plans for the future.


2Bessie Schless, op. cit., p. 320.
One patient, a young man who had had minimal tuberculosis, was planning to join the marines. The oldest female patient of the study was making plans to go to another city to live. Both were secure in their feeling that they would be able to make an adjustment in these new situations. Another patient had fears and doubts about facing her desire to marry. The case is discussed below:

Case 7

Miss H., a young woman of twenty years, had far advanced tuberculosis and was discharged from the sanatorium as improved after a stay of fourteen months. The physician recommended that she continue to rest in bed. A young man whom the patient had known for several years had proposed marriage. She was sure that he understood her illness and limitations imposed by it, but she felt that marriage would be unfair to him. She realized that if she discussed this with the physician, the answer to her problem would be somewhat clearer, however, she could not bring herself to do this. The Public Health Nurse was greatly concerned over the patient's medical condition which seemed to be growing worse. Unfortunately, this situation had not been referred to medical social service for help.

Another patient, an unmarried mother, was receiving a great deal of support from the medical social worker in adjusting to her twofold problem of unmarried motherhood and illness. A brief summary follows:

Case 12

Several months after discharge from the sanatorium, Miss R. learned that she was pregnant as a result of sexual intimacy with a married patient at the sanatorium. During pregnancy, the patient had difficulty in deciding whether she would keep the baby. This indecision was settled when it was recommended that the child be placed at least temporarily in order to safeguard the health of mother and child. The medical social worker, through a children's agency, placed the baby in a foster home. Meanwhile, the mother was able to work through her feelings towards the child with the help of the worker. She finally decided to keep the baby and has apparently been able to make a fair adjustment to her situation.
CHAPTER VII

CONCLUSION

Summary

This study of fifteen patients discharged from the Jefferson Tuberculosis Sanatorium resulted in some significant findings. There were two male patients in the group and thirteen females. The ages ranged from fifteen to forty-seven years. Four patients were married, six were single and the other five were widowed, divorced or separated.

Educational achievement among the fifteen patients was not very high; eight of them never passed the elementary grade level. All except one patient was affiliated with a church.

Most of the patients lived under adverse environmental conditions with inadequate housing, poor sanitation and deficient nutrition. Ten lived in urban communities near industrial sites. Fortunately, the environmental conditions of all the patients did not fall in this category. Five lived in pleasant rural communities. Two patients were adequately housed. Three-fourths of the fifteen patients were in the lower economic brackets, eight receiving meager help from the Department of Public Welfare.

Certain medical factors were of significance in this study. Four patients had diagnoses of minimal tuberculosis, seven had moderately advanced tuberculosis, and four had far advanced tuberculosis when first admitted to the sanatorium. Upon dismissal, the physical conditions of all except one patient had improved. One patient's disease was arrested. Eleven patients spent a period of six months or more in the sanatorium; the other four were hospitalized from one to six months. While in the
sanatorium, eight patients were placed on bed rest regime and the other seven were given surgical treatment.

Between one and two years after discharge, the patients were found in varying situations. Most were leading very sedentary existences from the standpoint of recreation and employment. With or without the help of medical social service, it was found that five of the fifteen patients had made satisfactory adjustments within the limitations of their illness. This adjustment was either due to their own emotional stability, the positive attitudes of others in the family or a combination of both. One patient had found employment, another was planning to leave the city, and a third had decided to join the marines. A fourth patient had found security in a very adequate husband, and a fifth patient, a veteran, seemed emotionally and intellectually equipped to deal with his problem.

In ten cases, adjustment was hampered or curtailed by various problems, some of which seemed to have been the result of illness and others which were apparently intensified by illness. Negative attitudes of some members of the families accounted for some maladjustment. In other cases, adjustment was obstructed by the patient's own inadequacies. In one case, a family tragedy precipitated a grave situation. The severity of the disease and the length of hospitalization apparently had adverse effects on adjustment.

Recommendations

Although the number of patients studied were few, the findings point to a need for the broadening of social services available to the patients. Fortunately, the Jefferson County Health Department is fully aware of this need and has recently taken steps to meet it. This is shown through the
recently inaugurated practice of interviewing and preparing social histories for all patients requesting admittance to the sanatorium. These histories, as a part of the social study, are extremely valuable in helping the doctors and nurses to understand the patient.

The visit of a social worker to the sanatorium once a week is another forward step; usually she spends at least a half day, and it is possible that this service will greatly reduce the problems that arise at the sanatorium.

Nevertheless, there are certain gaps in the services that need to be filled, although we are aware that the inadequacies are due to financial shortages. After reviewing these cases, it seems that the following suggestions might be pertinent:

(1) In each health center there should be at least one medical social worker to study, evaluate and treat in so far as is possible, each medical social situation.

(2) Because of the complexity of institutional problems, medical social workers should be added to the staff of the sanatorium, thus relieving the worker who must leave the health center once a week to visit the sanatorium. One social worker to every fifty or seventy-five patients is the accepted standard.¹

(3) For the patient who is discharged from the sanatorium, there is a need for more referrals to the State Vocational Rehabilitation Service. With the broadening of the medical social service program, this would probably materialize.

(4) A more consistent and intensive social service follow-up program is needed for discharged patients to help with adjustment difficulties.

(5) There is a need for more community-wide health programs such as is being done by the Anti-Tuberculosis Association of Jefferson County and the Birmingham Health Association. Such a broad and comprehensive educational program would not only stimulate community interest and focus attention upon the socio-economic factors associated with tuberculosis, but might eventually lead to social action which, after all, is the only solution to the problems of poor housing and inadequate assistance to those ill persons unable to provide medical care and subsistence for themselves and their families.
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SCHEDULE

A. Identifying Information

1. Name ___________________________ Age _______ Sex ___

2. Address __________________________ Rural _____ Urban ___

3. Marital Status S M W D Sep. Number of Children _________

4. Educational Status _____________________________

5. Religion _____________________________

6. Regular Occupation _____________________________

7. Major wage-earner in the home ________

   Amount of weekly earnings ________________

8. Is housing adequate? _______________ Explain _____________________________

   _______________________________________________________________________

9. Number in household ________ Adults ________ Children ________

10. Are there other tuberculous members in the family? ________________

    Specify relationship ____________________________________________

B. Medical Information

11. Date of sanatorium admittance __________

    Date of discharge _____________________________

12. Diagnosis on admittance to the Sanatorium (check):

    _________ minimal pulmonary tuberculosis
    _________ moderately advanced
    _________ far advanced
    _________ other (specify)

13. Stage of disease at discharge (check):

    _________ arrested
    _________ quiescent
    _________ improved

45
14. Type of Sanatorium treatment (check):

__________ bed rest
__________ pneumothorax
__________ surgery (specify)

15. Physicians recommendations at discharge (check):

__________ bed rest
__________ continue pneumothorax
__________ work ______________ Type of work
__________ other (specify)

16. Length of time since discharged from sanatorium (check):

__________ 6-12 months
__________ 12-18 months
__________ 18-24 months

17. Has patient continued follow-up care? ________

If not, explain why ________________________________

18. Has patient been employed? ________

Type of work ________________________________

19. Recreational activities since discharge from the sanatorium:

__________ movies
__________ parties
__________ sports
__________ club work
__________ other (specify)
__________ none

20. Describe reaction to first diagnosis and recommendations ________

____________________________________________________________________

21. Does patient worry over possible recurrence or setback? ________

____________________________________________________________________
22. Describe reaction of friends to illness


23. Does patient ever tire of inactivity? _____ Explain _____


24. Attitude of family

________ sympathetic
________ indifferent
________ impatient
________ other (specify)

25. Is patient known to medical social service? ______

Type of service rendered ________________________________