A study of the adjustment of patients with poliomyelitis who were discharged from the John A. Andrews Poliomyelitis Center located at Tuskegee, Alabama between June 1942 and June 1947

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A STUDY OF THE ADJUSTMENT OF PATIENTS WITH POLIOMYELITIS WHO WERE DISCHARGED FROM THE JOHN A. ANDREWS POLIOMYELITIS CENTER LOCATED AT TUSKEGEE, ALABAMA BETWEEN JUNE 1942 AND JUNE 1947

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
VIRGINIA MARIAN SLADE

ATLANTA, GEORGIA
JUNE 1948
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CHAPTER I

INTRODUCTION

Facts About Infantile Paralysis

The American Orthopaedic Association in its "Primer on Infantile Paralysis," published by the United States Children's Bureau 1946, gives the following definition of poliomyelitis:

Poliomyelitis or Infantile Paralysis is an acute generalized systemic disease caused by a virus and characterized by inflammation of various parts of the central nervous system, but particularly by the damage to, or destruction of, the large motor cells in the spinal cord, with resultant paralysis of the voluntary muscles innervated by them.\(^1\)

It is interesting to note that this definition does not state that polio is a communicable disease, although it is generally accepted that such is the case, even though just how it is spread is not definitely known.

The history of the disease is by no means confined to this century. As early as 1784, Dr. Underwood of London, in medical writings described it clearly. There is a possibility however, that it had occurred many years previous to that time, as there are probable cases found recorded in medical literature even back in ancient times.\(^2\) In 1835 in rural England, Dr. John Padham reported four classical cases of


\(^2\)Ibid.
two year old children. Five years later (1840), Dr. Jacob Heine, in Constatt, published a monograph describing the disease clinically and discussing its treatment.\textsuperscript{1} Twenty years later, (1860), Dr. Heine published another important article which dealt with the "spinal" character of this disease. Following this, there was much medical exploration by others, regarding the ailment and its central nervous system involvement.\textsuperscript{2}

The first epidemic in this country as noted by Dr. George Colmer, occurred in Louisiana in 1841; but Dr. Medin in 1893, was the pioneer who laid the foundation of our knowledge of the epidemiology of poliomyelitis.\textsuperscript{3} In Europe, infantile paralysis was sometimes referred to as Heine-Medin's Disease, because of the early and important contribution both these men made to its study.

It was in 1909 that it was demonstrated through the inoculation of monkeys that a filterable virus caused this crippling disease. In the years that have followed, much valuable information of a clinical, experimental and epidemiological nature has been accumulated and much progress has been made in treatment. We do not however yet know how

\textsuperscript{1}Ibid.  
\textsuperscript{2}Ibid., p. 2.  
\textsuperscript{3}Ibid.
the virus is transmitted, nor its mode of invasion of the central nervous system, nor is it definitely known how to develop an active or passive immunity to poliomyelitis. Science will one day find the answer to these unknowns and then it may be possible to eliminate the infection and offer positive protection from the disease. Infantile paralysis as a crippling disease leads the list of all others. Down through the years the victims of this dread ailment have taken their places in clinics and hospitals and doctors' offices throughout the world.

During the period from 1926 to 1946, there were 163,993 reported cases of poliomyelitis in the United States alone. Approximately 140,000 survived, among whom about thirty-three per cent have sustained some degree of visible physical limitation and many others are left with varying degrees of muscle weakness.\(^1\)

In the patient with infantile paralysis one is most frequently dealing with a child or adolescent. In the Chicago-Detroit area from 1939 to 1944 it was found that one-third of all patients fell in the age group from ten to nineteen; one-third were between the ages of five and nine, and one-fourth were under five. It is understood that there is mental pain and anguish present in the child or adolescent

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who, by virtue of his illness is abruptly withdrawn from practically all of his normal life's activities. The pain is intensified by the fear and apprehension that the patient experiences when he contemplates the possibility that he may be permanently disabled by his illness. As a rule, of course, he is unaware of the fact that fifty per cent of those who come down with infantile paralysis will show no after-effects, and that an additional thirty per cent will have slight after-effects, but practically normal movement. Actually, severe crippling maybe anticipated in only one out of five cases but to the individual patient, poliomyelitis is represented as a reality by the severely handicapped person he has seen walking down the street with long braces and crutches.¹

In this country, in our time, one of polio's victims by his triumph over the handicap, and the subsequent herculean tasks he was able to perform, became for all who have been blighted by the disease, an inspiration and an aspiration as well. The late President Franklin Delano Roosevelt, though he had been attacked with extensive paralysis, was able to take his place as the most important figure in the world's most powerful nation and to guide its destiny for a far longer

period of time than had any of his predecessors. He was a
symbol and a beacon light of hope for all those who have been
crippled by this disease, because he demonstrated the almost
miraculous capacities which are in the human mind and body to
conquer the ill effects of defects and injury which so often
follow in the wake of infantile paralysis.

The late President Roosevelt left a heritage to all
polio crippled, in the well known organization, The National
Foundation for Infantile Paralysis. Research has proved that
this foundation has done much in the mobilization of scientific
and medical forces for an all out effort to conquer this
disease.

Probably the most appealing portion of that work done by
The National Foundation for Infantile Paralysis, to the
millions of people who have pledged their support through
the March-of-Dimes, is the search for a preventive against
infantile paralysis.

A well known medical authority on the physically
handicapped, in discussing treatment of poliomyelitis, says
a great deal of the information made available to the public
is not only confusing but misleading. The lay person has
no way of evaluating claims of rival schools of treatment.
The man in the street also wants to know just how well and

1Henry H. Kessler, Rehabilitation of the Physically
for exactly what purposes is the money he is contributing, being used.

Dr. Kessler says that early treatment has to do with overcoming toxemia and saving life in the cases stricken with the type of paralysis which affects that part of the brain controlling the respiration centers. This is the deadly type which often proves fatal when the disease involvement is extensive. Some of the border-line cases however, can be helped by devices such as the iron lung, which does the work of the paralyzed chest muscles. These cases are exceptional, as more usually the paralysis affects one or more of the extremities. Treatment in such cases is to alleviate pain and prevent deformities.

The orthodox method of treatment stresses rest in bed - rest of the limb and protection against deformity by use of suitable splints. The newer method made notable by Sister Elizabeth Kenny of Australia, comprises hot moist applications and early motion and avoids the use of splints or braces.\(^1\) If cells supplying nerve function are destroyed by the virus, no type of treatment can restore them. Dr. Kessler feels that effective treatment often involves a combination of the two types. He makes no attempt to state which of the two methods is preferable but does indicate that "perhaps the

\(^1\) Ibid., p. 33.
truth is somewhere between the two.\(^1\)

Educational and vocational training for those who have been stricken with polio follows the pattern of that for all crippled children. Special schools are available in a large number of urban communities for the more severely disabled cases and classroom instruction is combined with physical and some pre-vocational training. The problem of retardation is not necessarily a reflection of mental capacity, but is often the result of complications related to treatment. A striking example of rehabilitation which bears significant witness of the value of training and education which state and local programs can foster, is illustrated in Dr. Kessler's book on "Rehabilitation of the Physically Handicapped." He describes an eighteen year old boy who came to the attention of the New Jersey Rehabilitation Commission in 1933. He was badly handicapped by extensive paralysis of the muscles of both shoulders and upper arm. Treatment included the fusing or stiffening of one of the boys' shoulders by an operation. This provided increased leverage for the weak muscles of the arm which as a result took on more volume and power. The young man was soon able to carry on his school work without difficulty. Under the guidance of the Commission an academic program was completed, resulting

\(^1\)Ibid., pp. 33-34.

\(^2\)Ibid., p. 35.
finally in a degree of Doctor of Philosophy. He was employed as psychologist in the Southbury Training School, Southbury, Connecticut. This is an example of what rehabilitation programs may accomplish, and also illustrates that a handicap need not be a deterrent, but instead may operate as a spur to human endeavor.

**Purpose of this Study**

The purpose of this study is to ascertain how certain poliomyelitis patients who were treated at the John A. Andrews Poliomyelitis Center and subsequently discharged, adjusted to their family, and community life upon return to their homes. To discover how they feel about their handicaps in relation to their ability to earn a livelihood. To discover whether or not this illness has tended to give them feelings of insecurity; or has it instead, intensified their desire to compete with their fellows.

**Scope**

This study is confined to polio patients admitted to the John A. Andrews Infantile Paralysis Center at Tuskegee Institute, Alabama from 1942 to 1947. All patients were from southern states with the exception of one who came from a northern state. The number of patients is limited to ten upon the suggestion of personnel at the Center.

**Method of Procedure**

The material for this study was obtained by interviews
with the hospital staff of the John A. Andrews Infantile Paralysis Center; that is, the physician, the nurse, the medical social worker, and the therapist. The two school teachers were also interviewed. Case records, schedules, and other background material such as pamphlets, bulletins, and books were used. (See appendix). As it was not possible to have face to face contact with these patients, it was necessary to employ the use of a schedule in the form of a questionnaire which was mailed to each. Personal data was collected in this manner. Because many of these patients lived such great distances from the Treatment Center, personal interviews with them were not feasible, although if possible, they would have been preferable.
CHAPTER II

THE SOCIAL AND EMOTIONAL IMPLICATIONS OF
POLIOMYELITIS

The broad concept of medical care for the child crippled by infantile paralysis does not any longer limit treatment to the correction, in so far as is possible, of his physical handicap only; but includes treatment also of the emotional and social ills which are likely to go hand in hand with the organic impairment. Few would disagree that there are emotional and unfavorable social factors inherent in any obvious handicap which sets a child apart from his fellows and limits his activity. There are implications of social difficulties in any medical treatment plan which requires long periods of care either in the hospital or convalescent home, which may be some distance from the child's own home. If the patient is convalescing over a long period in his own home, and requires meticulous nursing care, then it may add a burden to the mother who is probably already over worked. It is easy to see what this might mean in coloring her attitude toward her child. If she has several children, family worries, and a child so disabled that his care is a constant drain on her strength, she may consciously or unconsciously reject him. Her guilt over this may cause her to over protect the child, adding to his dependency and in no way meeting his needs or helping him to adjust so that he
may be assisted toward the goal of a useful and satisfying life.

Unless a child's medical treatment is integrated with his growth in social adjustment, education and vocational training, his real needs will not be met. The child who has been crippled by polio has the same needs as the normal child, but in addition he has certain other needs because of his illness.

His first need, of course, is for treatment of his crippling condition, and here in many instances parents resist recommendations for hospitalization and for surgery. It is in such cases that the social worker can do a job of interpretation and can help build up confidence in the medical institution and the medical staff. The social worker cannot help the parent to accept treatment recommendations unless the reasons for his non-acceptance of them are known. This means that the parent cannot be rushed, but the worker must necessarily take enough time in showing her acceptance and understanding of the parent's feelings so that he finally reveals the real reason for non-acceptance of treatment recommendations. It is well known that they often give some inconsequential reason at first for their resistance but when felt that they are understood by the worker and accepted, if given time, will usually bring out the real problem which is worrying them.

Social factors enter into the kind of treatment the physician gives a child who has been crippled by polio. He
considers whether the treatment can be given in the home rather than the hospital; whether he should operate or whether he should rely on braces and maybe reeducational exercises. His decision may depend on what the social worker has told him about the living conditions of the child's home, the intelligence and understanding of the parents, their attitude toward their child's illness as well as that of the child toward his condition. Sometimes his probable future occupation enters into the decision also.

Then when the time comes for the patient to leave the hospital and plans must be made for his after care, the social worker again gives attention to the social factors for she knows that if the family is unwilling to follow recommendations for after care, then the benefits of the hospital period can be lost. She interprets the home situation to the doctor, and his recommendations are made in the light of her social findings. During the period of the child's hospitalization, the social worker has, as a rule, been working with the family helping to prepare them and the home for the day that the patient is to return to it.

Sometimes no matter how hard the social worker tries to help prepare the home for the care of the patient upon his discharge, it still remains so unsuitable for care, that she resorts to foster home placement if no convalescent home facilities are available. Then too, interpretation of the very simplest kind of recommendation is necessary.
Sometimes the recommendation for a special diet cannot be carried out by the family without help from the social worker and a cooperative agency. Then again, special arrangements by the social worker have to be made for transportation to and from clinic in a great many cases.

The social worker knows well that there are many phases of family life that may be affected by the crippling illness of a member of the family. Sometimes brothers and sisters of a cripple have to go without necessities so that the ill member of the family may have the best. Sometimes parents' attitudes are resentful because of their inability to provide the needs of the crippled individual. Sometimes brothers and sisters are ashamed of the cripple in their home. The social worker is keenly aware of all of these situations and attitudes and in her work with the family and other cooperative community agencies knows how to help. She is also alert to the health problems of all members of the family, and directs her efforts in the interests of helping each to attain the very best adjustment of which he is capable.

One well known medical social worker has stated that social workers must analyze their own feelings toward and reactions to crippled children. They must not permit their desire for objectivity to cause them to assume certain poses and attitudes. They must constantly be aware of their own feelings because if they work with crippled children,
they become part of the environment to which they (the children), react.¹

Poliomyelitis, like most diseases of serious implications, and because of the possibilities of resultant paralysis, does often result in emotional and psychological trauma and of course, more so when the parents or the patient are emotionally unstable in the first place. This trauma can precipitate behavior problems which either might have existed previously or which might have just gone on being potentialities.²

Miss Copellman's Follow-up study in 1944 of one hundred children with poliomyelitis showed that children of all ages reacted to the experience, and that the severity of the reactions depended on factors other than age. The younger children became bewildered and withdrawn, but the older ones reacted in more aggressive ways and did not conform to their parents' demands upon them. According to Miss Copellman's findings, the severity of the reaction appeared to depend most on the emotional stability, past experience, and reaction of the parents, rather than on the severity of the disease and the amount of residual paralysis.³

¹Georgia Ball, "Case Work With Crippled Children," The Family, XX (April, 1939), 55.

²Fay S. Copellman, "Follow-up of One Hundred Children With Poliomyelitis," The Family, XXV (December, 1944), 296.

³Ibid.
There are a multiplicity of social and emotional problems in the adjustment of children to their home and school life after a crippling disease like poliomyelitis. If the social worker has an opportunity to work with the patients and their families during the illness and the convalescent period, she can more effectively assist in that adjustment and help in their achievement of a larger and fuller life.
CHAPTER III

THE HISTORICAL BACKGROUND OF THE JOHN A. ANDREWS INFANTILE PARALYSIS CENTER

The John A. Andrews Memorial Hospital at Tuskegee Institute, Alabama, of which the Infantile Paralysis Center is a unit, is thirty-four years old. The Infantile Paralysis Center was dedicated January 15, 1941 as a battle station in the nationwide fight against infantile paralysis. It was created by the National Foundation for Infantile Paralysis with more than half a million dollars given by the American people in the March-of-Dimes. It is a completely equipped medical institution. Airy wards, sun decks, treatment pools, physical therapy treatment rooms, plaster room, laboratory, brace shop, recreation hall, doctors' and nurses' offices make the Center, in conjunction with the surgical facilities of the hospital, a haven for Negro patients and medical specialists unique among hospitals anywhere in the world.

Ninety miles away from Tuskegee's Infantile Paralysis Center is the Georgia Warm Springs Foundation. It is said that Tuskegee is the same kind of institution as that, only on a smaller scale. Both are devoted exclusively to poliomyelitis and to the care of those patients whose crippling after effects of the disease offer unusual and

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challenging problems. Both are important as centers for clinical research and the education of professional personnel to care for victims of the disease.

Dr. F. D. Patterson, President of Tuskegee Institute says:

The Unit was not built with the idea of reaching all Negro patients, but to be a Center for training doctors, nurses, and physical therapists, and for studying unusual cases. It is taking some patients and will take more. The greatest good will come through the kind of cases successfully treated and the enriching experience afforded Negro doctors, among whom there are at present dangerously few orthopedic surgeons.\(^1\)

Tuskegee Institute was chosen as the location for the new unit because:

1. Its facilities - including its workshops in wood, metal, leather, etc., provided unusual advantages for the many patients requiring mechanical appliances and vocational training.

2. The average low humidity, mild winters and temperate climate of this section of Alabama provided beneficial and attractive environment for patients.

3. The population of the surrounding country for hundreds of miles in all directions was preponderantly Negro, making it logical to draw patients from not too great distances.

4. There was no other complete hospital for the care of Negro crippled children in the area from Nashville, Tennessee to New Orleans, Louisiana and from Atlanta, Georgia, to Jacksonville, Florida, although there were beds for them in several general hospitals.\(^2\)

The record of the John A. Andrews Hospital was worthy of the selection. In 1912, Dr. John A. Kenny, its medical

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\(^1\)Ibid., p. 9.

\(^2\)Ibid.
director, had organized there the first medical clinic of the National Negro Medical Association. Annually, the clinic has been held, and it is the largest and oldest of Negro clinics in the United States.\textsuperscript{1}

Dr. John W. Chenault, eminent young physician, Director of Orthopedic Surgery, is also chief of the Infantile Paralysis Center, and has been from its beginning. Assisted by consultants and private physicians of the area he carried on as the sole attending physician during the war period.

Dr. Chenault is a graduate of the University of Minnesota and a former Rockefeller Fellow in Orthopedic Surgery at both the University of Chicago and the University of Illinois. Before coming to Tuskegee he was Chief of the Orthopedic Department of Provident Hospital, Chicago, Illinois.

Physical Setting

The Infantile Paralysis Center of the John A. Andrews Hospital is a three story brick building. It is joined to the John A. Andrews Memorial Hospital by a cement ramp inclosed on either side by heavy glass windows which extend almost to the white cement floors. At the end of the ramp one goes through two heavy doors, part glass and part wood, entering into a small foyer which leads into a long parquet

\textsuperscript{1}Ibid., p. 10.
covered hall, with many doors on each side. If one turns to the front, there are two massive mahogany colored swinging doors which lead into a private waiting room. This is Dr. Chenault's waiting room, where his patients relax and await their time of appointment. It is attractively furnished with a wine colored leather divan, two wine colored club chairs, several other comfortable chairs, and a large mahogany side table laden with periodicals, the latest pamphlets, literature on infantile paralysis, and current magazines, suggestively arranged.

There is to the right, a door which leads to a large comfortable, bright room with numerous windows. This is the stenographic room, where the clerical work of the hospital personnel is done. Directly in front of this door is Dr. Chenault's private office. Upon entering it one sees that it is also attractively furnished with comfortable brown leather chairs, a wide shining mahogany desk and tall green file cabinets. Numerous books, magazines, different types of medical literature pour out of the ample bookcases that line the side of the wall.

Upon leaving the doctors' office and portion of the building one is faced with six rooms on the other side of the hall. There are three rooms on either side. There is on the right, the office of Miss Warenna Turpin, head nurse, then the plaster room, where casts are made, and last, the recreation center in which classes are conducted for
six hours each day by Miss Carrie B. Kinner and Mrs. Clara Belle Lewis, both graduates of Tuskegee Institute. The walls in the recreation room are decorated with handicraft of the patients. There are colorful samples of their endeavors all about, such as waste paper baskets of bright hues, vases with hand painted flowers, and on the windows are also hand painted flowers.

The other side of the hall is the laboratory where blood counts, urinalyses and other pathological examinations are made. There is also the brace shop where children's appliances are fitted. The last room on this floor facing the children's recreation center is the nurse's lounge furnished in green leather tipped with shining chrome.

The physical therapy treatment rooms are located in the basement with all of the apparatus necessary for administering the treatments offered by the Center. There is the gymnasium with the whirlpool and leg baths, electrotherapy machines; facilities for massages; a smaller room with exercise machines; a stainless steel Hubbard tank used for children who may not be permitted in the pool. The most beautiful sight is the pool. One looks at the pool through a protective covering of thick, clear glass. There it is, a shining thing, all shimmering green and as clear as crystal. It extends the length of the room in which it is built. There are gleaming metal guardrails and a hydraulic lift for the transfer of patients from their stretcher carts.
Mrs. Anita Patterson Grey, a registered physical therapist, is in charge of this department. She received the B. S. Degree in Physical Education from the University of Iowa and her Certificate in Physical Therapy from the University of California Medical School, August, 1946.

There are six rooms on the top floor where the patients are hospitalized. These rooms are window encased so that light and sunshine spill in upon the occupants. The beds are of white iron. Tables, chairs and dressers complete the furnishings.

The First Four Years

There were 101 patients admitted to the Infantile Center from March 1, 1941 to December 31, 1944. Most of them were from southern states, more than half from Alabama, Georgia, and the surrounding territory. In the four years there were only four deaths, two in 1941 and two in 1943.

One hundred and one persons, chiefly, hospitalized at the Center in four years seems pitifully few in a nation which in the year of 1944, saw more than 19,000 new cases of infantile paralysis. The significance of the 101, however, does not lie in their number, but in the fact that the staff was so small, and some of the patients were in such an advanced stage of crippling that only expert surgical treatment and reeducation could create noticeable improvement.

An indication of the size of the job done for the
101 persons lies in the fact that in 1944, with only one physical therapist employed, 2,323 physical therapy treatments were given. Of these, 832 were muscle reeducation, calling for the highest skills of the profession.¹

Admissions

In order to be admitted to the Center, according to an interview with the medical social worker, one must complete an application form which may be obtained from the office of the Director of the Center. At the present time, any Negro patient is eligible if he has been diagnosed by his physician as having infantile paralysis. This has not always been the case, however, for there has been in the past a waiting list, and it was formerly necessary for the Center to admit only those patients who could not get the necessary treatment elsewhere. Patients are classified as full pay, part pay and free. The full pay is eight dollars per day and part pay is four dollars per day.²

If a patient is unable to defray his expenses, he may obtain financial assistance through his local chapter of the National Foundation for Infantile Paralysis. Here hospital care, necessary appliances, and transportation are provided for those who are unable to pay. This is not as simple as it sounds, however. As a rule, the patient's

¹Ibid., p. 25.

²Statement by Louise Briscoe Trigg, Medical Social Worker John A. Andrews Poliomyelitis Center, Tuskegee, Alabama, personal interview, February 9, 1948.
doctor, who knows his entire social history, as well as the medical history and other vital information, refers the case to the local chapter for consideration; if accepted, the case is referred to the John A. Andrews Infantile Unit for further action.

Doctor Chenault's Job

Dr. Chenault's job is indeed an important one. It is based on skill and knowledge. It is from the doctor that information regarding technical questions may be secured. He knows the condition of the patient, the extent of physical involvement that exists, the specific treatment he considers most likely to provide desired results.

The following, according to Dr. Chenault, are some of his most important duties:

1. Complete physical examination upon entrance of patient, and routine medications.
2. After staff conference the program of treatment for the patient is formulated with the final approval of the Director.
3. Progress reports and check-up of each patient at intervals indicated by his individual condition.
4. Recommendations for physical, therapeutic and corrective rehabilitation procedures based upon a complete discussion of the patient at staff conference.
5. Prescriptions for all types of orthopedic and corrective apparatus.
6. Regular staff rounds conducted by the Director at which time necessary surgical procedures are advised and scheduled.
7. Consultations are held for all patients with
proper consultants from the John A. Andrews Memorial Hospital and the United States Veterans Hospital whenever deemed necessary.

According to Dr. Chenault, since the medical social worker, whom he considers a 'life saver' has been added to the staff, follow-up studies are better. They know what the patient is doing, when he will be back, and at last they are able to give adequate care for every child.

At a conference held in Atlantic City, New Jersey, during February 25-28, 1948, it was found that the John A. Andrews Poliomyelitis Center is making a unique contribution to the patients who are given medical help there, in that it is attempting to integrate vocational training with the total program of treatment.¹

The Medical Social Worker and her Job

The medical social worker, Mrs. Louise Briscoe Trigg, has been with the Center for eighteen months. She has had a rich experience in the field of medical social service. She received her training in this profession from the school of Social Service Administration, University of Chicago. She has worked as a medical social worker at Provident Hospital in Chicago, and as medical social worker in district offices of the Chicago Welfare Administration.

¹Statement by Dr. John W. Chenault, Director, John A. Andrews Poliomyelitis Center, Tuskegee, Alabama, personal interview, March 18, 1948.
Before coming to the southland, she served as Medical Social Consultant in the Public Assistance Program of Cook County, Chicago, Illinois, and was a field work supervisor for the University of Chicago, of selected students who were given a field placement in Public Assistance agencies.

Here at John A. Andrews Infantile Paralysis Center, Mrs. Trigg's services have been rendered in two big areas: (a) assisting the Director in setting up working relationships with agencies referring polio cases to the hospital; and, (b) working with agencies responsible for the follow-up care of the patients. She gives direct case work services to patients and acts as a consultant to Public Health nurses, and to social workers in other cooperating agencies.

Dr. Chenault refers all inquiries regarding applications for admission to the medical social worker for clearance and further exploration regarding eligibility and need for hospital care.

Type of Treatment Offered

The John A. Andrews Infantile Paralysis Center is devoted especially to those patients whose crippling after effects of the disease, indicate a need for skillful care.

In an interview with Mrs. Anita Patterson Grey, the Registered Physical Therapist, it was disclosed that when the patient is admitted, if it is indicated, he is given hot packs. Then, as his condition improves, muscle stimulation and muscle reeducation is introduced. This
treatment is taken directly from the Kenny method. They are also given mat exercises. For this particular treatment, straw mats are placed on the floor and the patient takes his exercise from this position. Exercises are given in groups or individually.¹

There is also the pool therapy treatment. The patients with acute involvement are never taken into the pool until they are pretty well on the road to convalescence.

¹Statement by Mrs. Anita Patterson Grey, Registered Physical Therapist, John A. Andrews Poliomyelitis Center, Tuskegee, Alabama, personal interview, March 8, 1948.
CHAPTER IV

MEDICAL CASE HISTORIES OF TEN PATIENTS WHO WERE TREATED AT THE JOHN A. ANDREWS INFANTILE PARALYSIS CENTER AND DISCHARGED

The patients in this study were hospitalized and treated at the John A. Andrews Poliomyelitis Center from 1942 through 1947. Ten in number, they ranged in age from seven years to forty. Due to extent of involvement, some were given intense treatment which lasted over a long period of time. Others not so severely affected were released much sooner.

At the time when the greater number of these patients were hospitalized, the Social Service Department, which was established eighteen months ago, was non-existent. This accounts for the lack of more detailed information as to the medical social worker's activities with these patients.

The medical social worker's first contact with the patients and their parents was at the Center. Her contact was only with those patients who came to the clinic after September 1946. She was interested in discovering what poliomyelitis, hospitalization, and convalescence in an institution meant to the patient as well as to his family.

The medical social worker was present at the Center throughout the examination of each patient and kept her record of the doctor's comments, the behavior of the child and pertinent statements of the parent regarding the child's reactions and behavior at home prior to hospitalization. In the case of adult patients, it was sometimes necessary to use
a casework technique - listening - in order that some interpretative help might be rendered. Adult patients as a rule wish to ask and have innumerable questions answered which the doctor and nurse often do not have the time to answer.

Inasmuch as most of the patients were from out of town, the medical social worker found it impossible to make follow-up visits after their discharge. Contact was maintained through letters to the parents or to the patient regarding further follow-up. Referring agencies cooperated by making reports at intervals to the Center regarding the discharged patient's progress.

Sometimes it was also necessary for the worker to give interpretation to the parents through the mail. This, in an effort to help both parent and child make a satisfactory readjustment to normal living.

In a discussion with the teachers at the Center, Mrs. Clara Belle Lewis and Miss Carrie B. Kinner, it was found that eight of the ten patients were at one time taught in the school provided by the Center. The other two patients did not attend, thus no information as to their personality make-up and adjustment while patients at the Center could be secured. Findings will be discussed briefly after each of the eight known cases.

The following cases were selected from the medical records of the Center for study because they had varying
degrees of poliomyelitis, and it was felt that such a study might provide interesting material regarding readjustment since their discharge. The group came from different environments, were of different ages, with varying educational backgrounds.

Case 1

Albert entered the Center June 12, 1942, at the age of eighteen years. Diagnosis was residual poliomyelitis. When admitted he was walking assisted occasionally by a crutch. This was a very old polio case with severe deformity of right foot and ankle necessitating amputation of lower leg type. He was fitted with an artificial leg. He was discharged from the Center December 22, 1943, completely ambulant. At time of discharge, he was able to ride a bicycle. While at the hospital, he received rehabilitation training in photography.¹

Case 2

Thelma entered the Center November 14, 1943, at the age of nine years. Her diagnosis was anterior poliomyelitis with loss of function in lower extremities. She was grossly overweight and badly handicapped in use of crutches and braces because of excess weight. Very drastic weight reduction of sixty pounds by diet, thyroid injections and exercise enabled patient to become quite active with braces and crutches. Surgery was required for severe bilateral valgus deformities of both legs. There was good corrective functional result. Upon patient's discharge May 6, 1947, she was greatly improved by loss of weight and correction of extreme deformities of both legs.

Thelma, according to the teachers, had never been to school before entering the hospital. She had never been to

¹The ten case records used in this study were taken from the medical files of the John A. Andrews Poliomyelitis Center, Tuskegee, Alabama.
a movie or attended church services. All of these experiences were accorded to her after entry at the Center. She attended school for four years while hospitalized and made good grades. During that time, she learned to crochet, knit and embroider. She was poised and even tempered and always anxious to help with the care of the smaller children. She was very polite and exhibited aggressive behavior only one time during her stay at the Center. According to Miss Kinner, Thelma had one of the best scholastic records of any patient who has ever attended the School.

Case 3

Mary, upon time of entry, February 14, 1944, was twelve years of age. Diagnosis was anterior poliomyelitis with residual flail right foot. Previous medical records revealed that at thirteen months, patient had paralysis. Hospital treatment was received at that time. Records also disclosed that at the age of eight years, Mary had what was probably a Campbell bone block of the left foot. As to treatment received at the Center, she was started on a general build up of physical therapy. Upon discharge August 28, 1944, patient was ambulant without crutches or braces, with only a moderate limp. She was able to walk to some distances about the campus.

Mary was very cheerful and did not worry about her handicap. She kept up with the current events, attended the school at the Center and did good work in Mathematics. She attended all social activities at the school and also took an active part in Sunday School.

Case 4

Lonnie was admitted to the Center January 15, 1943 at the age of twenty-one. The diagnosis was residual
poliomyelitis with severe involvement of the lower extremities. Upon entrance, patient was walking with braces, long leg type, and using crutches. Muscle power of extremities was very poor. There were no deformities, but a limitation of motion in both knees. General involvement offered little specific therapy. General physical therapy and muscle training was instituted in improvement of crutch walking. Occupational therapy linotyping was started with excellent results. Upon discharge, May 1945, patient was ambulant with long leg braces and Toronto crutches, and fully able to meet all daily requirements.

Lonnie was a high school graduate, and very anxious to learn a trade. An effort was made on the part of the officials at the Center to gratify this wish, with the result that he was given training in the operation of the Linotype machine. He was friendly with everyone. He was also a very diligent church worker.

Case 5

Brownell was admitted July 20, 1945 at the age of twenty-seven. The diagnosis was sub-acute poliomyelitis with involvement of lower trunk and extremities. The involvement was very severe. She responded well to muscle reeducation as far as possible, but was and is still, a wheelchair case. Upon discharge October 5, 1946, patient was able to use long leg braces and crutches moderately well.

Brownell was striken while her husband was overseas in the army. At the onset of her illness she had a six months old baby. According to both teachers, she was a wonderful person, and never seemed to be moody or to worry unduly over her condition, her home, or her child. While at the Center, she learned to tat and crochet. She was very apt and took part in social activities at the hospital. She
was a member of the Children's Social Club and active in Sunday School where she occasionally taught a class. Whatever inner conflicts this patient may have had, were not apparent in her outward behavior, at least to those with whom she came in contact while hospitalized.

Case 6

Edward was admitted to the Center January 3, 1946. The patient was severely involved in both lower extremities and spine. He responded well to rigorous Kenny Treatment and active scoliotic regime, becoming ambulant with crutches and gradually discarding back brace. Received training in shoe repairing and made very satisfactory progress. He planned to open a shoe repair shop. Upon discharge June 2, 1946, he was ambulant with crutches and well rehabilitated.

Most of Edward's schooling was done at the Center where he completed the ninth grade. He was a very religious person, a fluent speaker; apparently well adjusted, friendly and helpful with other patients.

Case 7

Charles, twenty-one years of age, was admitted September 21, 1946. Diagnosis was residual poliomyelitis of a chronic type. When admitted, patient was ambulant with crutches and braces, with severe lower involvement of extremities. Little return of function was achieved by the Kenny Treatment and pool therapy. His gait improved somewhat, and he was trained in the use of the Toronto crutches. Upon discharge June, 1947, his condition was much improved.

Charles was chronologically mature, being twenty-one years of age. Despite the fact that he had never finished high school and had been out of school for years, he was
anxious to learn. He studied very diligently, for he was interested in becoming self-supporting. His father was dead and his mother was a widow. He completed a trade in the Brace Shop. Both teachers remembered him particularly because of his wistful attitude. He was a cheerful person despite his physical handicap.

Case 8

Jeannette was nineteen years of age when she was admitted to the Center. Date of entry was September 1, 1946. Diagnosis was residual poliomyelitis of lower extremities. This patient was transferred from the University of Virginia Hospital. There was an involvement of both extremities and patient wore braces. Treatment was general physical therapy regime and build up. She was then taught use of crutches and improvement of gait. Rehabilitation was limited because of limitation of preliminary education. Upon her discharge May 23, 1947, gait was much improved and she was quite ambulant with braces and crutches.

Jeannette's environment had a great deal to do with her outlook on life. She had been out of school for three years and had become addicted to smoking and drinking. It took some time on the part of the teachers to help her realize that these were not good habits to be cultivated. It seemed that she was not interested in school, for at the time she left school, she was in the sixth grade. At the Center she first tried handicraft, but soon became bored with it. It was felt that her interest in school was stimulated when she was asked to make special book reports to the class. A warm relationship existed between her and another girl who was also being treated at the Center. The
other girl had an attitude that was directly opposite to Jeannette's. She was interested in studying and was far more advanced than her friend. In an attempt to compete, Jeannett later made a very good scholastic record at school.

Case 9

John was admitted to the Center May 1, 1946, at the age of nineteen. The diagnosis was residual poliomyelitis with paralysis of lower extremities including abdominal muscles. When admitted to the hospital, the patient was unable to walk or to move lower extremities. Patient was so severely involved that he was admitted as a total bed patient. Responded well to Kenny Type of Treatment and muscle reeducation. He became ambulant with crutches and brace. Upon discharge October 28, 1946 he was markedly improved.

John attended the school for a short while. He had been out of school for a long time and did not adjust to school life too well. The teachers noticed that he seemed to brood a great deal, and when questioned, said that he was worried about his condition.

Case 10

Pearlene entered the Center September 17, 1945 at the age of forty. Diagnosis was residual poliomyelitis with flaccid paralysis of the lower extremities. Left side affected less. Slight abduction of right thigh with use of accessory muscles. Inability to raise leg was noted. There was no movement of patient's toes on the right foot and very little or none on the left foot. Hamstrings on the left had one half or more of the normal power while those on the right were weak. Dorsi flexors of both toes were completely knocked out. Patient was grossly overweight upon admission. She was started on a weight reduction regime after careful study and basal metabolic tests. Chronic hypertrophic infected tonsils were removed and crutch walking, including stair climbing greatly improved. Patient showed great interest in beauty culture and was given instructions regarding this
work. Discharged August 20, 1946, at which time she was ambulant on crutches and with braces. Gait and ability to walk was improved. General health condition was good.
CHAPTER V

FOLLOW-UP STUDY TO ASCERTAIN HOW PATIENTS HAVE ADJUSTED TO HOME LIFE, FAMILY, AND THE COMMUNITY

The physically handicapped individual is again becoming the recipient of much attention. The public is more conscious of the problems of these individuals and the psychological effects sometimes resultant of the physical incapacities.¹

The neurotrophic virus disease, poliomyelitis, or infantile paralysis, as it is sometimes called, is well known for its contribution to the physically handicapped category. Whether the patient attempts to adjust as any normal individual who has not undergone such an experience should be interesting to observe. Does he marry with his limited capacity; seek remunerative employment and work; rear a family, or instead does he brood over his physical inability and attempt to do nothing to adjust and become self supporting? Of course, it is understood that the family, and the environment enter into the patient's attitude and have bearing upon his final attempt at adjustment.

Residual paralysis constitutes a major limiting factor, not only because of the impediment of locomotion of the

individual, but because of the obvious disability. It is felt that the degree of deformity is of great importance to the psychological adjustment of the patient.

A questionnaire was mailed to each of the ten patients in this study. Answers were received from eight of the ten inquiries. The investigation has revealed some interesting sidelights on the effect of physical limitation upon the capacity for social adjustment of a polio victim. Particularly significant is the fact that despite their physical limitations, the patients with the exception of one, in this study, have been able to become adjusted to the demands made upon them by their every day lives, and are able to render efficient services in a normal environment.

Case 1

Albert is now twenty-five years of age. He is not married, nor does he attend school. Since his discharge from the poliomyelitis Center, his only orthopedic appliance has been the under arm crutch. During his hospitalization at the Center he received rehabilitation training in photography, which resulted in employment by the local photographer at Tuskegee. He is able to be very active now. He walks up stairs as well as climbs, and reports having experience no difficulty in engaging in recreational activities. He has been able to adjust to his work as well and to his community. He dresses without assistance. The achievement in which Albert takes most pride is the fact that he now owns his own photography shop.

The fact that Albert has been able to start a business for himself is an indication of his perseverance and ability to return to normal life after discharge from the Poliomyelitis Center. Not only did the John A. Andrews
Poliomyelitis Center give Albert skilled medical attention, but the rehabilitation program carried along with the medical care, enabled him to become a self-supporting citizen.

**Case 3**

Lonnie is single, but does not attend school. Since his discharge from the John A. Andrews Poliomyelitis Center his orthopedic appliances have included long leg braces, under arm crutches, Canadian crutch and braces. He uses only the Canadian crutch now. He is active, can climb, descend stairs and participate in recreational activities. He has experienced no difficulty in adjusting to work, nor was it hard to assume the duties of community life. While a patient at the Center, vocational rehabilitation service provided him training in the operation of the linotype machine. He chose linotype operation because of his physical limitations which necessitated a sedentary occupation. Lonnie has been employed for a year as a linotype operator on a paper at his home town. He considers himself well rehabilitated and as having attained his desire of becoming a self supporting citizen.

Lonnie is the result of a carefully planned medical program, with a closely correlated vocational rehabilitation program. This program aims to help the patient realize that braces and crutches do not necessarily obstruct his efforts to live a happy and useful life, and that though he be handicapped, he still may be able to hold down a man sized job, as well as take part in social and political life. Even if he has lost a limb, and still has his mental faculties, he may increase his ability to become self supporting. Thus, the integration of a vocational rehabilitation program in the Center's program has helped prepare Lonnie to face a life of security.
Case 5

Brownell is now thirty years of age. Among the orthopedic appliances used by her since discharge she lists the wheel chair, long leg brace, and the Canadian crutch. At one time, she had to use both wheel chair and braces. She is able to open and close doors wearing her braces and using her crutch. She needs no assistance in donning or taking off apparel. Brownell has experienced no difficulty in adjusting to home life, nor the community. Her family has been very helpful and understanding.

In studying Brownell's activities since her discharge, there is no indication that she has experienced any particular physical difficulty in adjusting since leaving the hospital. It is impossible to know from the answers on a questionnaire just what the psychological meaning of the disease may have had for this patient.

Case 6

Edward is now eighteen years of age. He is single and does not attend school. Since his discharge from the Center he has used the under arm crutch and the Canadian crutch. He is able to be active, can climb and go down stairs with ease. He is able to dress and undress himself. He engages in recreational activities, has found it not at all difficult to adjust to life in general and to his community. He feels that his family has been very helpful in the process of his adjustment to home life and to society. Edward was given training in the vocational rehabilitation program at the Center. He chose shoe repairing.

Edward’s case is another example of the intense and well integrated program conducted by the Center. It has helped prepare him to have a feeling of security by assisting him in obtaining necessary vocational training for a life's
work which will serve as his incentive to become self supporting and independent.

Case 7

Charles is twenty-six years of age and is married. Since his discharge from the Center he has had to use long leg braces and crutches. Now he is active and can engage in recreational activities. He does the usual things a normal individual does. There has been no difficulty experienced in adjusting to the community, the home, nor in the area of work. His family has been helpful to him in every respect. He feels that he is accomplishing something despite his physical limitations.

One associates marriage with a more or less well rounded life. Charles has indicated that he has not allowed his physical impediment to prevent his seeking and participating in the things that any normal man appreciates such as home and family ties. His work is satisfactory. These results were attained after his discharge from the Center. He feels that the attention, counseling and understanding given him while hospitalized have helped him immeasurably in his every day life.

Case 8

Jeannette is now twenty-one years of age and is married. Her orthopedic appliances are the brace and crutch. She is active and engages in recreational activities; walks up and down stairs with absolute ease, and is able to climb to some extent. Her family has been helpful to her since her discharge from the Center. She does not look upon life as having been difficult since her discharge.

The fact that Jeannette has married since she left the
Center indicates that her handicap has not diminished her desire to lead a happy normal life. Though she is not employed she is occupied with home duties which apparently constitute a full time job. It is possible that she is a more stable and secure individual than when she was hospitalized. However, a questionnaire sent through the mails could not reveal that.

Case 9

John is now twenty years of age and single. He attends school and is in the eighth grade. He uses braces and crutches. He is able to dress and undress without help. His recreational activities are limited. His family has been helpful to him by offering him their understanding and sound advice as well as financial support to continue his studies in school. He does not feel that he has been able to adjust too well since his discharge, but has hopes for the future after he has completed his studies.

John's physical limitation has not decreased his desire to become independent. This is evidenced by the fact that he is once more attending school. It may be that this desire might have had its strengthening through help given him while hospitalized at the Center.

Case 10

Pearlene is forty years of age. She is single and now attending a trade school. She can dress and undress without any help, but is unable to engage in recreational activities, nor can she climb or descend steps. She feels that she has not succeeded in adapting herself to home life, the community and society. It is with the hope that she may become self supporting and better able to care for herself, that she is attending the trade school.

Though Pearlene does not feel that she has satisfactorily
adjusted to the home and the community since her discharge from the Center, it is felt that she has not lost her incentive to become an independent individual. This is obvious in that she is attempting to acquire skill in some specific type of work which may enable her to achieve at least a measure of security and independence.
Infantile paralysis dates back to the ancient Egyptian civilization. It was described clearly in 1784 by Dr. Underwood of London in his medical writings. In 1835 in rural England, Dr. John Padham reported four cases of two year old children. Five years later Dr. Jacob Heine in Constatt published a monograph describing the disease and discussing treatment. No epidemic was recognized in this country prior to 1894.

During the period from 1926 to 1946, there were 164,993 reported cases of poliomyelitis in the United States alone.

In 1938 the National Foundation for Infantile Paralysis was founded by the late President Franklin Delano Roosevelt to "lead, direct and unify the fight" against poliomyelitis.

There is no known cure for poliomyelitis. The orthodox method of treatment stresses rest in bed, rest of the limb, and protection against deformity by use of suitable splints. The most discussed method at the present is that made famous by Sister Elizabeth Kenny of Australia, which advocates the use of hot moist applications, early motion, and disregards the use of splints.

The John A. Andrews Poliomyelitis Center dedicated January 15, 1941 at Tuskegee Institute, Tuskegee, Alabama is
a national known battle station in the nation wide fight against infantile paralysis for the Negro. This Center was created by the National Foundation for Infantile Paralysis and is located ninety miles away from Georgia's famous Warm Springs Foundation which conducts a similar fight for the members of the white race. The Center is ably steered by Dr. John W. Chenault, capable and brilliant orthopedic surgeon and Rockfellow Fellow in Orthopedic Surgery. Dr. Chenault is assisted by consultants and private physicians of that area, and also aided by a well trained staff of highly qualified nurses, physical therapists, an occupational therapists, and an excellent, experienced, medical social worker, Mrs. Louise Briscoe Trigg.

This study of the ten patients who were treated and discharged from the John A. Andrews Poliomyelitis Center revealed several significant facts. At the time of admittance to the Center, the patient's ages ranged from seven to forty years. There were five males and five females. Only one was married. The married patient was a female.

The writer was able to make follow-up studies of only eight of the original ten selected cases because of the fact that the original number of questionnaires was not returned. Of this number, five returned questionnaires were from males and three from females. The follow-up studies revealed that four of the males were still single,
and one had married since discharge. One female patient had married since her discharge from the Center.

This study has shown that much is being done at the Tuskegee Poliomyelitis Center to alleviate to some degree the devastating results of the dreaded crippling disease. Here along with the expert medical care given the patient, a vocational rehabilitation program has been successfully integrated. This rehabilitation program has been sponsored by the Center in an effort to prepare the patient to better adjust upon his return home, despite his limited ability. It has been said that the Center is the only Care Center conducting such a work in conjunction with skilled and intense medical attention.

This study has further revealed that the vocational rehabilitation program whenever afforded the patients, has helped immeasurably in the individual's adjustment to society, and in his ability to become self supporting.

It is interesting and significant to note that the majority of the ten selected patients who were studied seemed to be helped by inner strengths emanating from their deep seated faith in God. While hospitalized, they were diligent workers in the Sunday School and Church conducted at the Center. They seemed to gain untold delight in helping each other, and also in aiding the smaller victims who were unable to help themselves. To the writer, this is an indication that religious beliefs served as a sturdy
bulwark in close conjunction with the medical and psychological help accorded the patients.

It is believed that much permanent harm can be avoided if help is given to those whose strengths are not sufficient to sustain the strain and anxiety endured when such a traumatic experience is thrust upon them. This enables the patients to readjust to their normal routine when the crisis is over.

There is no doubt that the Infantile Paralysis Center at Tuskegee Institute has done much good, and will do much more in its future fight against this dreaded disease. With the addition of the medical social worker to its staff, a complete follow-up study as to the continued improvement of discharged patients will be conducted. This will not only be helpful to the Center in the future fights it will wage, but will also prove of great value to the patients themselves.
APPENDIX
QUESTIONNAIRE

Age_________ Male_________ Female_________
Married_________ Single_________
In school? Yes____ No____ Grade____ Elementary_________
High School________________ College________________
Date you became ill with Poliomyelitis________________
Were you hospitalized? Yes____ No____ How many times_____
Names of hospitals________________
Length of hospital stay____________ Date of admission_____
Date of discharge________________
Check the kind of aid or appliance you had to use: Wheel chair
_____ Wheel chair and short leg braces________________
Long leg braces_____ Under arm crutch_____ Canadian crutch____
Shoe lift or elevation_____ Braces and crutches____ Cane____
Are you able to be active now, and do what is necessary in
your daily life demands?_______ Yes____ No_____________
Can you engage in recreational activities? Yes____ No_____
Are you gainfully employed?_______ Yes____ No____________
Has it been hard to make adjustment to your work? Yes____ No____
Has it been hard to adjust to life in general in your
community? Yes____ No____
Do you have any trouble getting in and out of an ordinary
straight chair with your braces on? Yes____ No_____
Can you climb? Yes____ No____ Can you come down steps? Yes____
No____
Can you open and close doors wearing your braces and using your crutch? Yes____ No_____ 
Do you dress and undress without assistance? Yes____ No_____
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