Medical-social adjustment of tuberculous patients to community life after discharge from the hospital: a study of thirty male veterans who received further care in the outpatient department, Veterans Administration Hospital, Memphis, Tennessee

Verona Shirley Shelton
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MEDICAL-SOCIAL ADJUSTMENT OF TUBERCULOUS PATIENTS
TO COMMUNITY LIFE AFTER DISCHARGE FROM THE HOSPITAL

A STUDY OF THIRTY MALE VETERANS WHO RECEIVED FURTHER
CARE IN THE OUT-PATIENT DEPARTMENT,
VETERANS ADMINISTRATION HOSPITAL, MEMPHIS, TENNESSEE

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
VERONA SHIRLEY SHELTON

ATLANTA, GEORGIA
JUNE 1951
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CHAPTER I

INTRODUCTION

Significance of the Study

It is a well-known fact that many anxieties, frustrations, and fears arise when a patient learns that he has tuberculosis and must be hospitalized for months and perhaps years. This long separation from society causes a breach in the patient's relationships with his family and friends. It is, therefore, to be expected that he would have some difficulty in readjusting to community life after his discharge from the hospital.

We usually think of people as being overjoyed upon learning that they are to be discharged from the hospital. But, on the contrary, this is not the case with many tuberculous patients. Very often they dread the thought of leaving the protection of the hospital and facing the complexities of work and life in the community.

It is not a rare thing to see symptoms recur in patients at the mere thought of discharge. Other patients, though unwilling to admit it, still feel an anxiety and uncertainty over their next steps.

The staff of the Social Service Department in the Veterans Administration Hospital for tuberculous patients in Memphis, Tennessee, and the writer decided upon this study of the adjustment of discharged patients to their families and communities, in an effort to ascertain whether or not the hospital or local agencies can better prepare tuberculous patients for

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their return to society. Specifically, the staff and the writer were concerned with finding answers to questions such as: How real are the fears of these patients? What problems do they face after discharge from the hospital? How does the community receive them? How are they helped to meet and conquer these problems? It is hoped that this study will reveal some answers to these questions.

Purpose of the Study

The aim of this study was: to determine how thirty male Negro tuberculous patients have made the transition from hospital living to a normal community life; to learn how these men have been accepted by their immediate family, relatives and friends; and to learn the problems—social, economic and emotional—they have met on their re-entrance to their respective communities.

Method of Procedure

These thirty patients (selected as described below) were interviewed on the day that they were in the hospital receiving "check-ups" or treatment in the Out-Patient Department. This Department was extremely cooperative in sending the patients to the Social Service Department so that schedules could be completed on each patient.

In many instances, these patients were known to the Social Service Department during their hospitalizations; therefore, these records were reviewed. Medical data was secured, concerning all of the patients, from out-patient and hospital records.

Conferences were held with the Social Service staff members, who willingly offered their suggestions and services in helping the writer to obtain the necessary data.
Reference material was secured from various books, articles, and pamphlets pertaining to the subject.

Scope and Limitations

This study included thirty male, Negro patients who were attending the Out-Patient Clinic during the period from November 1, 1950 through February 20, 1951.

Inasmuch as the majority of these patients resided in neighboring towns rather than in Memphis, the writer was unable to obtain collaborating material from the relatives and friends of each patient as to his adjustment to community life. Therefore, most of the attitudes and information secured were limited in accordance with the patients' knowledge and thinking.
CHAPTER II

VETERANS ADMINISTRATION SERVICES TO VETERANS

Origin of the Veterans Administration

The Veterans Administration is the result of a consolidation on July 21, 1930 of three federal agencies which served veterans: the United States Veterans Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.\(^1\)

The present administrator of the Veterans Administration, Carl R. Gray, is responsible to the President of the United States.

Hospital Services to Veterans

On August 23, 1935 Public Law 312, 74th Congress was approved. Liberalized eligibility for hospitalization provided that any veteran of any war who was in need of hospitalization and was unable to defray the necessary expenses thereof should be furnished hospitalization in any Veterans Administration facility within the limitation of beds existing in such facility, irrespective of whether disability, disease, or defect was caused by military service.\(^2\)

In each Veterans Administration Hospital, there is a Department of Physical-Medical Rehabilitation headed by a physician. This department offers some of the following services:

1. Physical therapy which is begun before the operation by teaching the patient how he should lie in bed after his operation.
2. Occupational therapy follows physical therapy.
3. Educational therapy is offered to veterans on all levels—grammar school, high school, and college. The physician decides when the patient can begin his studies.

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4. A vocational advisor helps the patient to select his final employment.

The Department of Special Services is concerned with the chaplaincy, canteen, library, entertainment and recreation of the infirmary and ambulant patients.

The many volunteer organizations help a great deal in maintaining the morale among the patients. ³

The patients secure information concerning their legal rights and available benefits from the contact representative.

The Social Service Department.—It has been said that the patient usually judges the help which he has received by the inner peace he has attained. ⁴ The social worker in the hospital setting endeavors to help the patient attain that inner peace.

Some of the medical-social problems with which the social worker helps patients are as follows: those which were caused, directly, by the patient's illness; those which already existed but were aggravated by the patient's illness; and those which had existed for quite some time and were not greatly affected by the patient's illness. ⁵

With casework in a hospital focused on the environmental and emotional problems which influence the patient's illness, and aimed at promoting the hospital's medical objective, this service becomes an integral part of the total medical program.

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⁴Irene Grant, op. cit., p. 11.

Out-Patient Department.—Out-patient services are offered to veterans with a service-connected illness or disability. However, a patient whose illness is non-service-connected can be eligible for out-patient services if his condition is associated with or is aggravating a service-connected condition. 6

This department serves those veterans who have been discharged from the hospital or do not wish to be hospitalized. As a result, it renders a great service in preventive medicine.

Description of the Setting

The Veterans Administration Hospital for tuberculosis in Memphis, Tennessee is the setting in which this study was made.

Approximately one hundred of the three hundred bed patients accommodated in this hospital are Negroes. On the basis of his eligibility for a particular service each veteran has at his disposal all of the hospital services (mentioned previously) which are rendered under the Veterans Administration.

The Social Service Department works quite closely with the medical staff and the Rehabilitation Department in an effort to help the patient obtain maximum hospital benefits, and to help in preparing the patient to face—with more confidence in himself—any problems which he might encounter as a result of his illness, on his return to the community.

CHAPTER III
THE DISEASE AND HOSPITALIZATION

Historical Background

There is evidence that descriptions of consumptives were passed orally from generation to generation years before the Hindu Vedas were written; therefore, it seems safe to say that tuberculosis probably existed on the plains of the Ganges in prehistoric times. One author said that the serious study of history leads one to believe that tuberculosis may have been the "first born of the mother of pestilence and disease."¹

The tuberculosis mortality rate among Negroes between the ages of fifteen through forty-four is about five times that of the Caucasians. Infection often runs a more rapidly fatal course in the Negro than in the white person. This seems to indicate a lesser degree of tolerance to the ravages of the disease, whatever the cause.²

Treatment Methods

Rest, of both the mind and body, is an extremely important remedy in the treatment of tuberculosis. Other treatment methods are used as a supplement to rather than a substitute for bed rest.

Collapse Therapy is one of the methods used by medical science to help the infected lung to rest. Collapse of the lung is accomplished through the injection of "air into the abdominal cavity" (pneumoperitoneum)

to push up the diaphragm.

Some other operations include: thoracoplasty, removal of the ribs around the diseased area; lobectomy, removal of part of a lung; and pneumonectomy, removal of a whole lung.

Many drugs have been used by scientists in an attempt to find a cure for tuberculosis. Parasalicylic acid, dihydrostreptomycin and streptomycin are among those used. Streptomycin is definitely not a cure for tuberculosis, but it has proved to be helpful in the treatment of certain types of the disease.3

Social, Emotional and Economic Problems of the Tuberculous Patient

For some patients who may have been under great emotional stress, admission to a sanatorium may mean a temporary, though unsatisfactory escape from problems which usually must be met again on discharge. This, of course, is not the reaction of all patients who receive a diagnosis of tuberculosis. It often comes as a blow to a man's ego and self-respect. There is also a fear of death as well as a fear of being socially ostracized.4

The first few weeks at a sanatorium are usually difficult and often tearful ones. The ranks of the family seem to have closed behind the patient before he was ready to become a member of the hospital community. Hospitalization means an exchange of the world of the fit for the world of


Most patients show resistance of some kind to being hospitalized. They may be dissatisfied with the treatment which they are receiving or with conditions in general. This is expressed very often through criticism of the personnel, the treatment regimen, and particularly the food, "the most convenient whipping boy."6

If the dissatisfaction is great enough, irregular discharge (leaving the hospital against the physician's advice) often results. Some of the usual reasons for irregular discharges are as follows: concern over affairs at home; such as, worry over family finances and economic status; and worry over security of family ties, including concern over infidelity of the spouse. Some of the problems of hospital adjustment which lead to irregular discharge are the inability to adjust to institutional regime; cravings for alcoholic or sex indulgence; and a desire to die at home if they must die.7

Upon his return home the patient usually finds that the world outside has not stood still while he was away. Many changes may have occurred during his long absence: the wife may have formed new ties, she may have learned to become self-reliant; the children may have grown up and might regard him as an intruder.

On the other hand, rejection and social ostracism may be in the patient's mind only. For him, life may become almost unbearable. He sus-

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5Eric Wittkower, _op. cit._, pp. 67-68.
pects slights and rebuffs when none were intended; and withdraws from society even when its members are quite willing to receive him.

It has been said that the social situation of the ex-tuberculous patient resembles, in many ways, that of the foreigner transplanted into another country, with the aggravating difference that the ex-patient has become a foreigner in his own country.8

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CHAPTER IV

CHARACTERISTICS OF PATIENTS STUDIED

Age, Marital Status, Dependents, and Living Arrangements

Tuberculosis does not attack a "chosen few" in any group. Young and old alike are struck down at a "moment's notice" by this disease. In this study, of the thirty patients, only two were World War I veterans. The age range (of the thirty patients) was from twenty-three to sixty-two: twenty were from twenty-three to thirty-three; eight were from thirty-four to forty-four; one was fifty-five and another was sixty-two years old.

Twenty-one of the patients were married; for two of them it was the second marriage. Seven patients were single. One patient was divorced, and one was separated. Of the married patients, all except two were from twenty-three to forty-four years of age; the other two were fifty-five and sixty-two years of age respectively. All of the single patients were from twenty-three to thirty-three years of age. The divorced patient was thirty-five years old; and the patient who was separated was twenty-six years old.

TABLE 1

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>Married</th>
<th>Single</th>
<th>Div.</th>
<th>Sep.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>30</td>
<td>21</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>23 to 33</td>
<td>20</td>
<td>12</td>
<td>7</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>34 to 44</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>45 to 55</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 and over</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Only one of the seven single patients had a dependent, his grandmother. The two patients who were divorced and separated each had one
dependent. Twelve of the married patients had children. The other dependents of these patients included mothers, fathers and a niece.

TABLE 2

DEPENDENTS AND MARITAL STATUS

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>30 1 1 1</td>
</tr>
<tr>
<td>Wife only</td>
<td>5 5</td>
</tr>
<tr>
<td>Wife and children</td>
<td>13 12</td>
</tr>
<tr>
<td>Other</td>
<td>6 4 1 1</td>
</tr>
<tr>
<td>None</td>
<td>6 6</td>
</tr>
</tbody>
</table>

The states represented in this study were as follows: Tennessee, Alabama, Mississippi, Arkansas, and Kentucky. Fourteen patients lived in rural areas and the remaining sixteen lived in urban areas. However, ten of these sixteen had moved to their present homes after their discharge from the hospital.

Of the thirty patients studied, three owned their homes, twelve rented their homes; eleven lived with relatives; two lived with friends; and two roomed.

TABLE 3

LIVING ARRANGEMENTS AND MARITAL STATUS

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>30 1 1 1</td>
</tr>
<tr>
<td>Owned homes</td>
<td>3 3</td>
</tr>
<tr>
<td>Rented homes</td>
<td>12 10 1 1</td>
</tr>
<tr>
<td>With parents</td>
<td>11 6 5</td>
</tr>
<tr>
<td>With friends</td>
<td>2 1 1</td>
</tr>
<tr>
<td>Rooming</td>
<td>2 1</td>
</tr>
</tbody>
</table>
Educational Status and Religious Affiliations

The grades completed by these thirty patients ranged from the third grade through college. Fifteen of the patients had completed the third through sixth grades; twelve, the seventh through tenth grades; two, the eleventh and twelfth grades; and one had completed his undergraduate training and planned to enter graduate school the school year after the study.

TABLE 4
AGE AND EDUCATION

<table>
<thead>
<tr>
<th>Age</th>
<th>Highest Grade Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
<tr>
<td>23 to 33</td>
<td>20</td>
</tr>
<tr>
<td>34 to 44</td>
<td>8</td>
</tr>
<tr>
<td>45 to 55</td>
<td>1</td>
</tr>
<tr>
<td>56 and over</td>
<td>1</td>
</tr>
</tbody>
</table>

It was found that twenty-nine of the patients were Protestants and one was a Catholic.

Occupations Prior to Hospitalization and Vocational Training

The occupations of the patients were many and varied: thirteen were farmers; three did mill work; two were carpenters; three were cooks; and there was one person in each of the following occupations: supply teacher, factory worker, furnace repairer, steel plant worker, anesthetist, construction worker, butcher, plasterer, and student.

Inquiry about the patients' vocational training under the "G. I." Bill revealed that twenty patients had some vocational training in the following: clerical work, tailoring, shoe repairing, carpentry, watch-
making, barbering, cabinet making, plastering, auto mechanics, or plumbing. Three of the twenty had been employed in their fields of training. One of the ten patients who had no vocational training expressed a desire to begin training as soon as the doctor said that he was able to do so.

Present Source of Income

The long period of enforced idleness combined with the continual warning against overstrain may produce a state of 'fear of work' in the patient due to the feeling that any exertion will have dangerous consequences.¹

It is interesting to note that of the thirty patients studied, only two expressed a desire to work: one of these patients admitted that his doctor said he had a "spot on his lung," but, because he "never felt ill a day in his life," he did not accept the doctor's diagnosis; the other patient was a World War I veteran who received a pension, which he said was not enough to support him and his wife adequately.

Some of the reasons for not working which were offered by the other twenty-eight patients were as follows: "The doctor said I was not well enough to work." "I get tired and have to rest, so I decided to take it easy." "A person who has had tuberculosis is never supposed to work again."

If the patient's disability is service-connected, he is awarded compensation; if the disability is non-service-connected he is given a pension. Twenty-six of the patients received compensations; and the other four patients received pensions. Those patients who were attending school received money for that purpose.

¹Norvin C. Kiefer, M. D., op. cit., p. 238.
It is significant to note that nine out of the eleven patients who received compensation and who had a wife and children depended entirely on the compensation for their income. Only one of these eleven patients had a wife who was working. She was also the only working wife of the twenty-six patients who were receiving compensation. Ten of the twenty-six patients receiving compensation were attending school and, therefore, were given money for that purpose.

The above-mentioned information regarding wives' work, et cetera, is based on the statements of the patients.
CHAPTER V

MEDICAL INFORMATION REGARDING THESE PATIENTS

Admission Diagnosis

Some patients discovered their illness quite by accident during a mass x-ray program. Others, who had been feeling ill, were told that they had tuberculosis by their private physicians or by hospital physicians.

The extent of the infection when their diagnoses were made was as follows: eight had minimal; twelve, moderately advanced; and ten, far advanced tuberculosis.

Number and Length of Hospitalizations and Treatment Received

All except two of these patients had been hospitalized in Memphis. In determining whether or not each had been a patient in more than one hospital, it was learned that eight patients had been in only one hospital; nine in two hospitals; eleven in three hospitals; and two in four hospitals.

The treatment received by each patient was determined according to his particular need. Bed rest, however, was an essential in the treatment of all of the patients. They received any one or a combination of the following: bed rest only; drug therapy; surgery; and one said that he had been placed in an oxygen tent. (The methods of treatment mentioned in this paragraph include those which were received in all of the hospitals where they were patients). The length of hospitalizations of these patients varied from four months to five years. Some were continuous hospitalizations, while others were interrupted through irregular discharges.
TABLE 6
LENGTH OF HOSPITALIZATION AND DIAGNOSIS AT ADMISSION

<table>
<thead>
<tr>
<th>Length of Hospitalization</th>
<th>Total</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Far Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>30</td>
<td>8</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>14 mo. to 1 yr.</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>13 mo. to 2 yrs.</td>
<td>12</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>25 mo. to 3 yrs.</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>More than 3 yrs.</td>
<td>4</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Discharge Diagnosis

The patients received the following types of discharges when they left the hospital: nineteen, regular discharges (with the doctor's permission); nine, irregular discharges (without the doctor's permission); and, two, disciplinary discharges (because of misconduct).

When a patient is discharged from the hospital, a diagnosis is made regarding his physical condition. The following are some of the terms that are used:

Arrested: No constitutional symptoms. Negative sputum, lesions stationary and apparently healed according to x-ray examinations; no evidence of pulmonary cavity. These conditions existing for 6 months; the last 2 months of which the patient takes one-hour walks two times a day.

Apparently arrested: No constitutional symptoms, negative sputum; lesions stationary and apparently healed according to x-ray; no evidence of pulmonary cavity. These conditions existing for 3 months; the last 2 months the patient takes one-hour walks daily.

Quiescent: No constitutional symptoms. Sputum may be positive. Lesions stationary or retrogressive according to x-ray; cavity may be present. These conditions existing for two months. The patient is ambulant all of this time.¹

¹Edward W. Hayes, Tuberculosis As It Comes and Goes (Illinois, 1947), pp. 165-66.
When the writer was unable to obtain the patients' discharge diagnoses from their clinical records, it was necessary to depend totally upon the information which they gave regarding their diagnoses.

In most instances, the patients who had irregular discharges had about the same diagnoses upon discharge as they had upon admission to the hospital. However, in three cases out of the eleven irregular discharges, the patients had apparently improved and had the following diagnoses: two of these patients had an admission diagnosis of moderately advanced tuberculosis; however, upon discharge, one was an arrested case and the other was an apparently arrested case; the other patient had an admission diagnosis of far advanced tuberculosis, and upon discharge he had an arrested case. Of the regular discharges, eighteen had arrested cases and one was apparently active but improved.

Out-Patient Services

Lapse of time after discharge.—At the time of their interviews, two of the patients had been re-admitted to the hospital—one for observation and the other because he was seriously ill. The remaining twenty-eight patients had been receiving out-patient services for a period of eight days to four years.

Frequency of out-patient appointments.—These patients' appointments for "check-ups and/or pneumoperitoneum (defined on page 7) ranged from once a week to every six months, depending upon their individual needs.

It is interesting to note that, according to their statements, none of the patients had missed a single appointment, regardless to how many years they had been receiving out-patient services. One of the two following reasons might account for this significant fact: the hospital personnel were quite successful in impressing upon the patients their need
for and the value of continuing their examinations and treatment after dis-
charge from the hospital; the patients may have "over-learned" their les-
sons to such a degree that they actually pampered themselves unnecessarily
because they were afraid of over-exerting themselves and thereby causing a
relapse.
CHAPTER VI

FOLLOW-UP STUDY

Upon his re-entrance into the community, the tuberculous patient, knowing his limitations, must choose the road which he thinks will best lead him to a satisfactory adjustment to his new life. He may join the small group of persons who are in a position which is similar to his. He may decide on becoming a part of the new environment and may succeed in being accepted or, by over-doing it, in being rejected by the group. He may—"throwing reason to the wind"—choose to ignore his limitations and cling to the old life that he loved.1 Whatever his choice, the patient finds that this new life is entirely different from the one that he lead while in the hospital community.

The patient who returns to his family and community is a "man apart" if he attempts to live as he did in the hospital. Unless he has an exceptional family, he will have to adapt himself to the pattern of living which has been formed in his absence from the home; the family will not adapt their lives to fit his.2

Many patients describe a sense of strangeness after their return home. Of course, they are glad about their regained freedom yet, "like released prisoners," they imagine that everyone knows about their "past domicile." No longer supported and sheltered by the hospital, they are apt to feel uncertain of themselves, anxious and insecure.

Those who are not so concerned about themselves may be afraid of

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1 Eric Wittkower, op. cit., pp. 82-84.
2 H. A. Pattison, M. D., op. cit., p. 61.
infecting others. While hospitalized, they lived in a "community of fellow-sufferers;" upon discharge, they may think of themselves as a menace to their loved-ones and the community.³

How the patient is able to adjust to his life outside of the hospital is greatly dependent upon the reactions of his family to his return home. Usually, one can withstand the knocks and rebuffs of the world when he knows that he will receive understanding and consolation from his loved ones at home.

Family Relationships

All of the patients stated that their family relationships were the same as they had been before their hospitalization. Those who shopped for groceries, handled money matters, et cetera, before they left home, took up their job upon their return. (Some of the patients spoke of these as the "man's job").

In telling about his family relationships, one of the patients was so vague and hesitant that the writer wondered if all was as well at home as he said. This case is cited below.

Case 1

Mr. A., aged thirty-six, was married and had one child, a son. Since he was hospitalized for approximately five years, Mr. A. saw his son very seldom. In fact, he said that he did not want to be "around his son" until he was "grown" as he did not want to "take any chances" on his son's getting tuberculosis.

Mr. A's wife and child lived in Indiana, where the three of them had previously made their home; but, Mr. A. had been living in Mississippi with his parents ever since his discharge from the hospital eight months before the study. He explained this separation by saying that he did not like the hospitals in Indiana and it was too cold there for him. His wife visited him in

³Eric Wittkower, op. cit., pp. 80-81.
Mississippi about a year before, but she continued to live in Indiana because the child could get "better schooling there." Mr. A. said that a man who had had tuberculosis really "had no business" with a wife.

Marriages after discharge.—Four of the patients married after their discharge from the hospital. One of these men was engaged before he became ill. All of them, except one, had children; and all said that they and their wives got along quite well together.

One author said that there are risks involved when an ex-tuberculous patient marries. However, there should be little danger if the proper precautions are taken; such as, being certain that the disease is arrested; the couple should be fairly secure economically as the tuberculous person will not be able to do any laborious work; the couple should have a thorough understanding of the limitations of the one who is tuberculous. It has also been found that tuberculous people may safely have children so long as the person's infection is well healed and he is well nourished.4

The following case is an illustration of a marriage which took place after the patient's discharge from the hospital.

Case 2

Mr. C. was a twenty-four-year-old, tall, muscular looking young man. He, his wife, and their child resided in Mississippi, where he farmed before his illness.

During the one year that he was hospitalized, Mr. C. had some ribs and a part of one of his lungs removed. A scar was left on his back as a result of this operation. Although Mr. C's wife had seen the scar and had been told what caused it, she did not believe that he had had tuberculosis.

Mr. C. got the same reaction from his friends when he told them of his illness. They merely laughed and said, "There's nothing wrong with you. You're too fine looking to have had tuberculosis."

4H. A. Pattison, M. D., op. cit., pp. 115-16.
Although the patients, as a whole, were met with a warm welcome when they returned home, all of them probably had some doubts as to how they would be received when they first learned that they were to be discharged from the hospital. One, however, was probably free of doubts regarding his welcome, because his wife, too, was tuberculous. This case is as follows:

Case 3

Mr. D. was thirty-eight years of age. He had completed the first year of high school and worked as an anesthetist before he became ill.

During the five months that he was hospitalized, his only treatment was bed rest. The social worker continued contacts with him throughout his hospitalization. Whenever the social worker inquired about Mr. D.'s wife, he spoke of her as being a sickly person; but he never said exactly what was wrong with her. He would shrug his shoulders and say, "You know how women are—always sick."

Mr. D. requested that his wife be given some financial assistance until his claim for disability was adjudicated. In order that his request could be fulfilled, it was necessary that a visit be made to his home to determine his wife's need. This visit revealed that Mr. D.'s wife had had tuberculosis for several years and was receiving nursing care and treatment in her home.

It was not until his social worker informed him of her knowledge of these facts that Mr. D. admitted that his wife had been tuberculous for many years. Even then he was quite reticent about the entire matter, and it was never learned why he was so unwilling that his secret be revealed. It might have been that he was afraid that he would not be granted a service-connected disability compensation if it was learned that his wife had had tuberculosis long before he entered the service. On the other hand, he might have felt that he was infected by his wife, but was never willing to verbalize this idea.

One patient's wife was so eager to have him at home that he finally felt impelled to leave the hospital against medical advice in response to her pleas. His case is summarized below.

Case 4

Mr. E., aged twenty-seven, was married and had two children; another child was expected soon.
During his eleven months of hospitalization, Mr. E. made several requests for financial assistance for his family. However, he never received any assistance as the social worker who visited his home did not think that the family's need was very great.

Mr. E's car was re-possessed by the company, during his hospitalization, because no payments had been made on it, at that time, for approximately four months.

The final blow seemed to come when one of Mr. E's three children died; his wife became quite ill after the child's death. It was believed that her illness might have been caused by worry over the child. Mrs. E. was described by a Department of Public Welfare worker as "very insecure with many needs of her own." When she wrote to her husband, she constantly complained and blamed him for the home situation. She even implied that she did not think that he was sick enough to be in the hospital when she was at home alone with so many worries. Finally, Mr. E. decided to leave the hospital so that he could relieve his wife of some of the problems of the home.

Quite contrary to the case cited above is the case of a patient who left the hospital against medical advice and was brought back to the hospital on the following day by his relatives. This case is as follows:

**Case 5**

Mr. F. was a twenty-four-year-old unmarried veteran. He had a girl friend before he became ill, but he "broke off with her" when he learned that he had tuberculosis.

Mr. F. seemed to be a quiet, easy-going, likeable young man. However, during his entire hospitalization, he was unable to get along with his roommates.

Upon his return from a trip home, he was found with a gun and a whiskey bottle in his possession. His explanation was that he thought it would be interesting to own a gun; but he had no intentions of harming anyone. He was given a disciplinary discharge the following month for disorderly conduct.

Mr. F. had been home only a short time when he became quite ill and had to be re-admitted to the hospital. When he began to feel a little better, he decided to leave the hospital as he said that the other patients were bothering his private property. He left, but, on the following day his brother-in-law brought him back to the hospital because his family realized that he was too ill to be at home.

Mr. F. told his social worker, when she visited him, that he could remain in the hospital if the other patients did not bother him; and he asked her to pray that they would not bother him. A few days later, Mr. F. attacked some of the hospital personnel with a knife and fork. This, along with his previous actions, seemed to be just cause for transferring him to a hospital where he could be kept under observation. The diagnosis which was made
as a result of this observation was that he suffered from "mild paranoid delusions." His family took him out of that hospital almost immediately when they learned why he had been sent there.

Several months later, Mr. F. was again re-admitted to the hospital for the tuberculous because he had a very severe hemorrhage. It was at this time that the writer interviewed him (he had been receiving out-patient services while he was outside of the hospital). About two weeks later, Mr. F. left the hospital against the doctor's advice, though he was quite weak and ill.

Social Adjustment of the Patients

Even though the discharged patient might feel healthy and strong, he is usually more a part of the world of the unfit than of the fit. His activities are usually slowed down and he is "debarred from a hectic social life." Rather than spoil the fun for others, some withdraw completely from the company of their friends. As a result, they become more aware of their disability and, thus, are more frustrated.5

Some of the patients in this study tended to withdraw from society; however, fortunately, most of them who attempted to continue their friendships found that they were not shunned and ostracized, but were accepted with their limitations.

Fifteen of the patients had made new friends since their discharge from the hospital; some of them had an entirely new group of friends because they had moved to different communities, for various reasons, after they left the hospital. The other fifteen patients had the same friends that they had before their illness.

In attempting to learn how these patients were received by their friends after their discharge from the hospital, they were asked if their friends (new or old) knew of their illness. Twenty-one of the patients tolerated with their limitations.

5Ibid., pp. 117-18.
said, very definitely, that their friends did know of their illness. Among the other nine, some were quite vague in their answers, and others candidly admitted that they did not want anyone to know that they had had tuberculosis.

Those who made their illness known had varied experiences and reactions from their friends. Summaries of some of their experiences follow:

Case 6

Mr. G., aged twenty-four, married after his discharge from the hospital and had two children. He was hospitalized for one year and twenty-four days.

Mr. G. said that most of his friends acted the same towards him. He was surprised, though, to learn that some of those persons whom he was certain would have "stuck by him" were not so friendly after he became ill. However, he had decided to "ignore" those people as he had learned who his true friends were.

Case 7

Mr. H., aged thirty-nine, was married but had no children. His only dependent, beside his wife, was his mother. Mr. H. said that he could see no difference in his friends' actions towards him since his discharge from the hospital.

Case 8

Mr. I., aged thirty-seven, was married and had no children. He did not go out as much as he used to as he needed a lot of rest. However, his friends acted the same as they always did. He felt that it depended upon who one's friends were and where one lived as to whether or not they "frowned on" one because he had had tuberculosis.

It seems significant that two or three of the other patients also mentioned that it depended upon one's friends and his particular community as to how he was treated if he was tuberculous. One of these patients said that the air in his home town was filled with dust, et cetera from the mills. This seemed to weaken the lungs of many of the people thus making them more susceptible to respiratory diseases. As a result, so many of
the people had tuberculosis that a "newcomer with tuberculosis" was automatically accepted in that community.

The patients who did not want their friends to know of their illness did not know from experience that they would be ostracized, but they felt certain that they would be if their secret were revealed. Some of their cases are summarized below:

Case 9

Mr. J. was an unmarried man, twenty-four years of age. He was hospitalized for one year and two months. He explained this absence from home to his friends by saying that he was visiting an uncle in Memphis.

Mr. J. said, "Tuberculosis is the wrong thing to tell people about because it is a contagious disease." He knew that people would "dodge him" if they knew that he had had tuberculosis; and he would not blame them, because if he had not had tuberculosis himself, he would not be "bothered with" anyone who had had it. If he could possibly prevent it, none of his friends would ever know of his illness, because he knew he would have "hard luck everywhere" and would lose all of his friends.

Case 10

Mr. K., aged thirty-one, married after he was discharged from the hospital four years before the time of this study; he had two children from this marriage.

Mr. K's wife knew of his illness before she married him as they were courting when he became ill. Most of his friends knew that he was ill for two years, but they did not know that he had tuberculosis. When anyone asked Mr. K. about his illness, he merely said that he had "a run down in health." He was afraid that if they learned what his illness was, they might act differently towards him.

Case 11

Mr. L., aged thirty-three, was married but had no children. Of all the patients whose friends did not know of their illness, Mr. L. seemed to be the most seriously disturbed. Although he had been discharged from the hospital for three years, he was still full of anxiety and apprehension when people were around him.

The reason for Mr. L's constant uneasiness was that he was afraid that "people would dishonor him" if they knew that he had had tuberculosis; they might feel that he "had no business being around them."
Although the Social Service Department seldom had any further contacts with the patients after their discharge from the hospital, so extreme was Mr. L's anxiety that the writer asked him if he would like to talk with a social worker about his problem. (The patients in this study were not included in the writer's caseload; and the writer was leaving the agency in a few days, so she suggested that Mr. L. might talk with her supervisor). Mr. L. eagerly accepted the offer for help in this area; he said that he certainly needed to talk with someone about his feelings.

Church Attendance and Leisure-Time Activities

After a very long and disabling illness, some people become embittered and turn their backs on the church; others, thankful for their recovery, draw closer to the church; those remaining are usually relatively unconcerned about the matter. The writer was attempting to learn if there was an outstanding example of any of these attitudes among these patients since theirs was an illness which is usually stigmatized.

The patients' answers were as follows: sixteen went to church as often after their discharge from the hospital as they did before their illness; ten went to church less than they did before their illness (several of them explained this by saying that they did not like to be in crowds); one patient had been discharged only one week and had not been to church; and three went to church more than they did before their illness.

Exchanging visits with friends is always an important part of one's social life, so the patients were asked questions in this regard. Some patients exchanged visits with their friends quite often. Others did little or no visiting themselves but their friends visited them. A few, who were uncomfortable around people, did not visit nor did they have any visitors beside their relatives.

Seven of the patients were members of a club. One of these patients, Mr. D. (see case on page 23), belonged to four clubs. He was not an officer
after his discharge from the hospital; but he held an office in the Masonic Lodge before his illness. Another patient, also a Mason, stated that he held the office of "worshipful master," which he explained was comparable to the president in a club. The other clubs to which the patients belonged were as follows: Elks, American Legion, Veterans of Foreign Wars, Disabled Veterans. One belonged to a college fraternity, but he seldom attended their meetings because he could not "keep those late hours."

The remaining twenty-three patients either were not interested in being a member of a club; or, if they were interested, there were no clubs in their neighborhoods to which they could belong.

During their leisure time many of the patients went hunting and fishing, played cards, and went to the movies. Seven of the patients said that they did none of these things, but spent all of their time resting or sleeping.

Health Practices of the Patients

All of the patients said that they gave special attention to their diets and rest, as these are two health practices which play a very important part in helping the tuberculous patient to stay well.

Twenty-five of the patients had three meals daily; the other five had two meals daily with occasional "snacks." The hours of rest which the patients got night and day ranged from eight to twenty. Some of the patients said that the greatest amount of time which they spent away from home was on the days when they went to the hospital for their out-patient appointments.

When questioned about their indulgence in intoxicating liquors, the patients gave the following replies: seven of the patients did not drink
before their illness and did not drink after their discharge from the hospital; one of the patients who did not drink before his illness began drinking, moderately, after his discharge from the hospital (he was unable to give an explanation for this change); two of the patients who drank before their illness could not drink after their discharge from the hospital as it made them "sick;" the other twenty patients said that they drank before their illness and continued to drink a little after their discharge from the hospital.

All of the patients seemingly knew their limitations as well as the health practices which they must follow in order that a breakdown might be prevented. According to their statements, they took extremely good care of themselves, as their long period of hospitalization and treatment was an experience which they did not wish to repeat.
CHAPTER VII

SUMMARY AND CONCLUSIONS

Summary

The serious study of history leads one to believe that tuberculosis may have been the "first born of the mother of pestilence and disease." There is no cure for tuberculosis; however, drug therapy and surgery have played an important part in controlling the spread of the disease within the infected lung. These treatment methods are used as a supplement to rest, which is an extremely important remedy in the treatment of tuberculosis.

From its birth to the present day, there has always been some stigma attached to this illness. However, public education has, no doubt, contributed to the fact that a tuberculous person is not shunned to the same extent today as years ago. In spite of society's change of attitudes, when a person learns that he has tuberculosis and must be hospitalized for months and perhaps years, he is immediately filled with fears and anxieties as to what the future holds. The long period of hospitalization causes a breach in the patient's relationships with his family and friends. It is, therefore, to be expected that he would have some difficulty in readjusting to community life after his discharge from the hospital.

This study was decided upon in an effort to learn what problems these thirty Negro male patients met in their communities after their discharge from the hospital; and to ascertain whether or not the hospital or local agencies can better prepare the tuberculous patients to meet any problems which they might encounter in making the transition from hospital living to a normal community life.
The Veterans Administration has already seen the need for such services to tuberculous patients as well as those persons with other illnesses. Therefore, each Veterans Administration Hospital has a Social Service Department within its setting. The social worker is a member of the medical team which is headed by the physician and consists of the nurse, rehabilitation staff and psychologist. The social worker focuses on the environmental and emotional problems, and the other team members focus on the physical and psychological problems. All are working towards the same end—to help the patient obtain maximum hospital benefits; and to prepare him for taking his place as a useful citizen in his community.

During his hospitalization, the tuberculous patient is faced with social, emotional and economic problems, to say nothing of his complaints about his confinement and the treatment regimen. These are the types of problems with which the social worker attempts to help the patients. However, the anxieties and frustrations of some patients are so great that there is nothing that anyone can do to prevent their leaving the hospital against the physician's advice.

The Out-Patient Department offers the patients continued treatment and "check-ups" after they have been discharged from the hospital. It, thereby, helps the patients to maintain the health which they regained during their hospitalization.

The age range of the thirty patients studied was from twenty-three to sixty-two years. Twenty-one of the patients were married; seven were single; one was divorced; and one was separated from his wife. Of the seven single patients, only one had a dependent, his grand-mother. Twelve of the married patients had children and the two patients who were divorced and separated each had one dependent.
All of the patients were from southern states. Fourteen lived in rural areas and sixteen lived in urban areas. Three of the patients owned their homes; twelve rented their homes; and the remaining fifteen lived in the homes of relatives or friends.

The grades completed by these thirty patients ranged from the third grade through college. Prior to their hospitalization these patients were employed in many and varied occupations: thirteen were farmers; three did mill work; two were carpenters; three were cooks; and there was one in each of the following occupations: supply teacher, factory worker, furnace repairer, steel plant worker, anesthetist, construction worker, butcher, plasterer, and student. Of the twenty patients who had had vocational training, only three had been employed in their fields. None of the patients worked after their discharge from the hospital; however, two of the patients expressed a desire to work as soon as the physician gave them permission to do so.

The sources of income of these thirty patients, after their discharges from the hospital, consisted of one or a combination of the following: service-connected compensations; non-service-connected pensions; money for vocational training, if they wished to attend school; and their wives' work.

When these patients entered the hospital, their diagnoses were as follows: eight had minimal; twelve, moderately advanced; and ten, far advanced tuberculosis. The length of their hospitalizations varied from four months to five years. In three cases out of the eleven irregular discharges, the patients had apparently improved and had the following diagnoses upon discharge: two were arrested cases and one was apparently arrested. Of the regular discharges, eighteen had arrested cases and one was apparently
active but improved.

Twenty-five of the patients had three meals daily; the other five had two meals daily with occasional "snacks." The hours of rest which the patients got night and day ranged from eight to twenty. Some of the patients said that the greatest amount of time which they spent away from home was when they went to the hospital for their out-patient appointments; otherwise, they were at home relaxing.

Questions about their indulgence in intoxicating liquors revealed that seven of the patients did not drink before their illness and did not drink after their discharge from the hospital; one of the patients who did not drink before his illness began drinking, moderately, after his discharge from the hospital; two of the patients who drank before their illness could not drink after their discharge from the hospital as drinking made them "sick;" the other twenty patients said that they drank before their illness and continued to drink a little after their discharge from the hospital.

Some patients exchanged visits with their friends quite often. Others did little or no visiting themselves but their friends visited them. A few, who were uncomfortable around people, did not visit nor did they have any visitors beside their relatives.

Sixteen of the patients went to church as often after their discharge as they did before their illness; ten went to church less than they did before their illness; one patient had been discharged only one week and had not been to church; and three went to church more than they did before their illness.

Seven of the patients belonged to some club; the remaining twenty-three patients either were not interested in being a member of a club; or,
if they were interested, there were no clubs in their home towns to which they could belong. Other leisure-time activities named included hunting, fishing, card playing, and attendance at the movies. Seven of the patients said that they did none of these things, but spent all of their time resting.

The type of adjustment which the patient is able to make to his life outside of the hospital is greatly dependent upon the reactions of his family and friends to his return home. One can usually withstand the knock and rebuffs of the world when he knows that he will receive understanding and consolation from his loved ones.

As a whole, these patients were fortunate in receiving a warm welcome from their families when they returned home from the hospital; and they resumed their places as the "head of the house." One of the patients, however, was a little reticent and vague in his answers about how he was received by his family; this lead the writer to believe that possibly his illness had brought about an unfavorable change in his relationship with his family.

Four of the twenty-one married patients had married after their discharge from the hospital; and three of them had children. All of these marriages, according to the patients, were successful and happy ones.

Twenty-one (a majority) of the thirty patients studied, found that, with few exceptions, their friends willingly accepted them with their limitations into the group. The other nine patients had no way of knowing whether or not they would be accepted as they were afraid to tell their friends about their illness.
Conclusions

The following conclusions were drawn as a result of this study: It seems that the patients' fears of being shunned and ostracized by all of their friends are based more on their knowledge of the stigma which was attached to tuberculosis years ago than on the situation as it exists today. Apparently, the problems with which these patients were faced after their discharges came, largely, not from their families or their communities, but from within the patients themselves. The one outstanding problem which most of the patients had in common was that they seemed to have over-protected and pampered themselves. Possible evidence of this is seen in the following facts:

1. None of the thirty patients worked after their discharge from the hospital. In mentioning this, the writer is not unaware of the fact that all of the patients are not, nor will they ever be, able to work again. Also, there is the possibility that those who are able to work might have some difficulty in securing a job because of their disability. However, there is no way of knowing what the outcome would be since, according to statements made by the patients, none of them had tried to find work and only two expressed a desire to do so.

2. According to their statements, none of the patients had missed a single appointment, regardless to how many years they had been receiving out-patient services. (One patient stated that he had missed one of his appointments because he did not know that he was expected on that particular day. In consideration of this patient's reason for missing the appointment, the writer included him in the above-mentioned group). It should be encouraging to the medical team to know that these thirty patients do place a great deal of importance upon continuing their
treatment and "check-ups" after their discharge from the hospital; but, it seems that the 100 per cent record of attendance of all patients may be another indication that they have "over-learned" the hospital's teachings regarding their limitations as tuberculous persons.

3. It is a well-known fact that a great deal of rest (relaxation and sleep) is a necessity, not only for the tuberculous patient who is trying to get well, but also for the discharged patient who wishes to maintain his health. However, it seems logical to suppose that some of these patients may have been getting much more rest than was necessary. If this be true, then here is further proof of the possibility of self-pampering on the part of these patients. According to their statements, fourteen of the patients got twelve or more hours of sleep a day; seven of these got from fifteen to twenty hours of sleep a day.

On the basis of the above-mentioned facts, these recommendations are offered:

1. Twenty-eight of the patients seemed to be quite contented not to work. However, without their realizing it, their mere presence at home during the day, while other men of their ages are at work, probably serves as a constant reminder that they are different from their fellows. This, in turn, may lead to feelings of inferiority and fears of being frowned on and rejected by any new persons who learn of their illness. Therefore, the writer believes that while information about the patients' limitations cannot be neglected, more emphasis might be placed on the positives of the life which they can lead, without danger of a relapse, after their discharge from the hospital.

2. Through the years, great strides have been made, by public educa-


persons. However, as long as there are patients who live in constant fear lest their closely guarded secret be revealed, there can be no cessation of the education of the community to which the patient must some day return.
SCHEDULE

IDENTIFYING INFORMATION


5. Address________________________  6. Rural_____  7. Urban____

8. Marital status: S____ M (Date)____ D (Date)_____ Sep. (Date)____

9. Dependents other than wife: Chn. (No.)____ Other________________

10. Education (Grade completed)____  11. Vocational Training___________

   a. Own work
   b. Wife's work
   c. Relatives
   d. Pension____ Compensation____
   e. Other (Specify)________________

14. Living Arrangements:  15. No. of rooms____________________
   a. Own home
      (1) Relatives or roomers living with you: Yes____ (Specify)____ No____
   b. Home of relatives____
   c. Rooming____
   d. Home of friends____

16. After discharge did you return to your old address? Yes____ No____
    (Describe fully)________________________________________________________

17. Employment:
   a. Type of work before illness__________________________________________
   b. Type of work after illness__________________________________________
18. Did you have a difficult time finding employment? Yes____ No____
   (Describe fully)__________________________________________

19. If same job, do you have the same employer? Yes____ No____

20. If you have not worked since discharge, why? (Explain)__________

MEDICAL ASPECTS

21. How long were you hospitalized? Years______ Months______

22. Where were you hospitalized? Here____ Other____

23. In how many hospitals have you had treatment? (No.)____

24. Admission diagnosis:_______________________________________

25. Type of treatment while hospitalized:
   a. Bed rest only ______
   b. Antibiotics (Specify)____________________________________
   c. Collapse therapy:
      (1) Pneumoperitoneum______ (3) Surgery (Specify)___________
      (2) Pneumothorax _______ (4) Other______________________

26. Discharge diagnosis:________________________________________

27. Length of time out of hospital: Years______ Months______

28. How often do you come for OPD treatment?____________________

29. What type of treatment are you receiving now?
   a. Pneumoperitoneum ______
   b. Pneumothorax ________
   c. X-ray only ________
   d. Other (Specify) _______
HEALTH HABITS

30. Do you miss OPD appointments? Yes____ (How many)____ No____

31. Why did you fail to keep appointments?
   a. Boredom ________ (Explain)
   b. Indifference ________
   c. Forgetfulness ________
   d. Other ________

32. Do you habitually stay out late at night? (Explain)

33. How many hours of rest do you get? (Night and day)

34. Alcoholic beverages:
   a. Did you drink before illness? Often_____ Seldom_____ Never_____
   b. Do you drink since illness? Often_____ Seldom_____ Never_____

35. How many meals do you eat a day? (No.)_____

36. Do you attend movies? Yes____ (How often)____ No____

37. Do you play cards? Yes____ (How often)____ No____

38. Do you do friendly visiting? Yes____ (How often)____ No____

39. Do you invite friends to your home? Yes____ (How often)____ No____

40. Do your friends know of your illness? Yes____ No____
   a. If not, why? (Explain)

41. Have you made new friends since discharge? Yes____ No____

42. Do you belong to any clubs? No____ Why not? (Explain)
   a. Yes____ What kind?
   b. Do you hold any office? Yes____ (Specify)____ No____
43. Do you attend church often? Yes ___ No ___
   a. Have you been more active in church since discharge? Yes ___ No ___

IF SINGLE:

44. Do you have a girl friend? Yes ___ No ___
   a. One special ___ b. Several ___

45. Do you and girl friend go out alone: Always ___ Seldom ___ Often ___ Never ___

46. Does your girl friend know of your illness? Yes ___ No ___
   a. If no, do you intend to tell her? (Explain)

DESCRIPTION OF HOME LIFE

47. Who does the buying? You ___ Wife ___ Other ___ (Specify)

48. How often do you and family spend evenings at home together:
   Seldom ___ Often ___ Never ___

49. How often do you and wife go out together? Seldom ___ Often ___ Never ___

50. How often did you go out together before your illness?
   Seldom ___ Often ___ Never ___

REMARKS:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
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