Public Health Reports

Vol. 63 • NOVEMBER 5, 1948 • *No. 45*

— Editorial —

Hospital Beds for the Tuberculous

From plans submitted by the States and Territories to the Hospital Facilities Division, we learn that there are now 84,874 hospital and sanatorium beds for the tuberculous—exclusive of those in tuberculosis preventoria and Federal hospitals. This number does not, of course, reflect the many variations of purpose, construction, and location of the hospitals containing these beds, nor for that matter, the type and quality of services available to patients. At best, we can say only that these 84,874 are the beds upon which we can rely for 1 of the 2 purposes of a sanatorium—isolation. Moreover, only 71,916 of this total are considered "acceptable" by responsible State agencies.

Even if all the 84,874 beds now available were acceptable, we still would not begin to meet the standard of 2½ beds per annual tuberculosis death. Many thousands more will have to be provided. To meet the need, many of the States are currently developing added facilities, and it is appropriate to review the trends which are becoming apparent in this effort.

For example, there is a growing interest in locating tuberculosis hospitals near the centers of population which they serve. At long last, it appears that the tuberculosis sanatorium will begin to come out of its traditional isolation. This is promising, for it forecasts many improvements and many benefits which will accrue ultimately to the men and women sick with tuberculosis, to their families, and to the community. For one, central location gives the sanatorium access to the consultative and direct services of physicians specializing in fields other than chest diseases. Welfare and rehabilitation services become more available to greater numbers of sanatoria and are more readily integrated with individual sanatorium programs. As the tuberculosis sanatorium moves into a more favorable competitive position for the services of nurses, technicians, attendants, and housekeeping aides, personnel problems should be alleviated markedly, turn-over reduced and the present acute dearth of vital workers relieved.

In many communities where construction programs have been planned, and in some cases undertaken, authorities have been forced

to limit these for the time being because of rapidly spiraling construction costs. Many localities, however, have with determination and ingenuity developed alternate measures for the provision of at least a small portion of urgently needed beds. In some areas, surplus hospital facilities have been utilized to good advantage. In others, existing structures have been converted to temporary hospital facilities. Still other communities are contemplating the integration of tuberculosis services with existing general hospitals.

This latter course is indicated either where there are no sanatoria to which additions can be made, or where expansion is undesirable because of the remoteness of existing sanatorium facilities. It is also appropriate where the necessity for providing additional heating facilities, laundries, kitchens, surgical suites, radiological and laboratory services, and maintenance departments makes impracticable the expansion of existing sanatorium facilities or the construction of new wings.

Administratively, there is much to recommend the practice of integrating tuberculosis hospital facilities with those of a general hospital. This is especially true when a general hospital possesses central services and resources which can provide for the additional patient load. Indeed, even where separate construction is practicable, it is desirable to consider locating the tuberculosis unit adjacent to the general hospital, thus permitting the use of common facilities. Operating economies and increased efficiency should not fail to result.

In a joint arrangement the opportunities for training physicians, nurses, and attendants in tuberculosis are unexcelled, and the demand for such training will assuredly increase. Furthermore, the tuberculosis department in such an organization would benefit from ready consultation with physicians in the general hospital, and could, in turn, offer many of the valuable professional services of specialists in tuberculosis and other chest diseases. Obviously, therefore, adding a tuberculosis wing to the general hospital would be entirely consistent with the aims of tuberculosis control.

It is most encouraging that communities throughout the Nation are taking increasingly aggressive and resourceful action to provide hospital care for the tuberculous. Even though the devices which are currently being adopted do not completely wipe out the bed deficiency, the changes in approach will undoubtedly produce improvements in the quality and effectiveness of tuberculosis care and treatment.

Tuberculosis control workers may therefore take heart from these recent developments. In the final analysis, it will not be by weight of numbers that control facilities will contribute to the defeat of the tubercle bacillus, but rather by their accessibility, availability, and effectiveness.

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IRREGULAR DISCHARGE

The Problem of Hospitalization of the Tuberculous [1]

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The Problem

Between July 1946 and June 1947 there were nearly 6,000 cases in which patients who required hospitalization and treatment for tuberculosis "walked out" of Veterans Administration hospitals. By contrast, there were less than 5,000 cases in which tuberculous patients were discharged after completing hospital treatment. In other words (excluding transfers to other hospitals for continuation of hospital treatment), 54.4 percent of the discharges from VA hospitals of living tuberculous patients were "irregular" [2] and only 45.6 percent were "regular." For every five discharges of tuberculous patients who had received the maximum benefits from hospitalization, there were six discharges of patients still injuriously affected by tuberculosis who put an end to further hospitalization by their own act. Patients irregularly discharged represent a menace to the community and to themselves: to the community because of the danger of spreading infection; to themselves because the almost inevitable consequence of their actions is physical deterioration, need for subsequent re-hospitalization, and sometimes death.

Of patients receiving irregular discharges between July 1946 and June 1947 whose condition at time of discharge was reported, 49 percent were discharged "unimproved." Only 12 percent of the living patients discharged after completing hospitalization were "unimproved." A study of patients irregularly discharged from VA hospitals during July 1947 revealed that 62 percent left with diagnoses of far or moderately advanced active tuberculosis. Within 5 months, 29 percent of those whose whereabouts and status were known were already back in hospitals. Of 170 with far advanced active tuberculosis, 23 had already died—22 of them from tuberculosis.

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[1] Condensation of VA Pamphlet 10-27, same title and author, published by the U. S. Government Printing Office. Published by permission of the Administrator, who assumes no responsibility for the opinions or ideas expressed.

[2] An "irregular" discharge is any termination of hospitalization of a living patient not sanctioned by professional authority. Discharges "against medical advice" (sometimes termed "against advice," "at own risk," or "voluntary" discharges), post factum discharges which occur when a patient leaves the hospital or remains absent from the hospital without prior approval or without notifying the authorities (i. e., discharges because of absence without official leave—AWOL) and discharges ordered by a disciplinary board because of misconduct or other violations of hospital rules are all "irregular" discharges. A "regular" discharge, as the term is used in this study, means any termination of hospitalization of a living patient which is medically sanctioned. Transfers (hospitalization not terminated) and deaths are considered types of dispositions of hospital patients, but are not considered discharges.

Why do these irregular discharges of tuberculous patients occur? What causes men who are ill to turn their backs on hospital treatment which provides the means of enabling them to return to reasonably useful and normal living? What can Veterans Administration do, or refrain from doing, that will encourage its tuberculous patients to remain in hospitals until they have received the maximum benefits from the medical skill available to them? This study was initiated in an attempt to answer these questions.

Incidence of Irregular Discharge

Because of the consequences of irregular discharge and the large proportion of such discharges from VA hospitals, the problem for Veterans Administration is serious. But to what extent is it peculiar to VA? Is it a problem of the tuberculous *veterans*, or of the *tuberculous?* Do most tuberculous patients in non-VA hospitals [3] remain in hospitals until treatment is completed? Are there influences to which tuberculous veterans are subject that do not equally affect tuberculous non-veterans? Finally, are there in VA hospitals conditions that do not occur in non-VA hospitals?

Few studies have been made on rates of irregular discharge of the tuberculous. Those that are available cover widely varying periods and areas. Rates are not always computed in the same manner. Those for VA hospitals are based on number of discharges. In studies of non-VA hospitals, the rates are generally based on the number of patients discharged. It follows that rates for VA hospitals would be lower if they were based on number of patients discharged, for many veterans have histories of repeated irregular discharge from one or more hospitals. The total number of irregular discharges in a year is increased by the number of "repeaters" who are included more than once.

Studies of rates for non-VA hospitals also differ from those for VA hospitals in the classification of patients transferred from one hospital to another. Non-VA hospitals even differ among themselves in this respect. Transfers from non-VA hospitals are generally few, but in VA hospitals transfers are a major proportion of total dispositions of tuberculous patients (22 percent during fiscal year 1947).

In order to make the irregular discharge rate for VA hospitals more nearly comparable with rates for non-VA hospitals, transfers were excluded from the calculation entirely and were considered neither regular nor irregular discharges. The same was true of deaths.

One of the earliest studies of this problem shows that 71 percent of discharges from the National Sanatorium of Tennessee in 1923 were

[3] Throughout this study, "non-VA" hospitals refers to all hospitals other than VA hospitals, including those in which no VA beneficiaries are hospitalized as well as those in which veterans are hospitalized under VA auspices.

irregular (*1*). Another demonstrates that at least 32 percent of 6,906 patients discharged from 75 public sanatoria in 16 States during 1933 were without consent (*2*).[4] Of 4,190 patients discharged from Wisconsin sanatoria from June 1924 to June 1934, 61 percent left against advice (*3*).[5] This group included 1,037 patients with far advanced tuberculosis on admission, of whom 83 percent left irregularly.

Such instances can be multiplied. Studies in public sanatoria in Pennsylvania, Ohio, Iowa, New Jersey, New York and the District of Columbia all support similar conclusions (*4, 5, 6, 7, 8, 9*). Though rates of irregular discharge vary, they are everywhere so high that they constitute a major problem.

Adequate data on irregular discharge of patients from private sanatoria are not available but the rates are believed to be lower than for public institutions. Nonetheless, observations of numerous authorities indicate that this is a harassing problem in private sanatoria also. Far from being peculiar to the Veterans Administration, irregular discharge appears to be an almost universal phenomenon in the care of the tuberculous. VA hospitals may have greater or lesser rates than particular non-VA hospitals for given periods, but the high incidence of irregular discharge is not characteristic of tuberculous veterans only.

It should also be noted that in no other disease is irregular discharge a comparable problem. One never hears of irregular discharge of orthopedic patients or of plastic surgery patients. An exhaustive search of the literature fails to disclose a single study or discussion of the problem in connection with any other disease.

The cause of irregular discharge must be sought in the nature of the disease, the nature of the treatment and the nature of the tuberculous patient—or in a combination of all three.

Social and Psychological Implications

Tuberculosis has many characteristics in common with other illnesses. There are, however, certain special characteristics which make it unique in its social and psychological implications. Recognition of these factors is basic to any attempt to understand the behavior of the tuberculous—in hospitals and out.

Tuberculosis is a disease for which no specific, sure and permanent cure has yet been developed.

Treatment of tuberculosis generally requires a relatively long period of hospitalization.

[4] Some transferred and even furloughed patients were included among those with regular discharges (recognized by the authors as one of the shortcomings of the data—op. cit., pp. 23, 32). If they were not so included the irregular discharge rate would undoubtedly have exceeded 32 percent.

[5] Classification of transfers not specified.

Tuberculosis is a dreaded disease with fear, open or disguised, as an almost universal concomitant—The fear which is so common among the tuberculous is not only of physical damage and death, but also of the social and personal consequences of hospitalization. To many, tuberculosis is still a social stigma. Confronted with long hospitalization the patient fears loss of his economic security, separation from and possibly rejection by his family and friends. He is consumed with a sense of failure.

Prolonged rest, the basic treatment for tuberculosis, contradicts one of the elemental needs of human nature: the need to seek release of emotional and psychic tension in action—Patients do not leave their tensions and anxieties behind when they enter a hospital, and new tensions and anxieties are added by the need to adjust to a totally different and, to the patient, sometimes hostile environment. As part of his treatment, the patient is expected to relax completely—physically, emotionally, even mentally. But while the body rests, emotional and psychic energy accumulate. These cannot be freely discharged in activity. They manifest themselves therefore in tensions and irritability. It takes a balanced, well-supported personality to overcome the contradiction inherent in treatment for tuberculosis.

Emotional and Psychic Aspects

In any attempt to understand the behavior of tuberculous patients, consideration of the emotional and psychic factors is fundamental. And yet it is in this area that confusion, misunderstanding, and unfounded generalization abound. Lawrason Brown says, "Contradiction contradicts contradiction and the tuberculous patient is described as anything between an insane criminal and a saint too ethereal for this mundane sphere. You can pick your articles and take your choice of his character" (*10*).

Much of the confusion found in the literature arises from the failure to distinguish between two different problems—one the psychic factors in the etiology of tuberculosis, the other the psychic states which develop from having tuberculosis. Conclusions pertinent to one of these problems are often applied to both, whereas each represents a separate and distinct sphere of inquiry.

To consider the first: is infection with tubercle bacilli sufficient to produce tuberculosis, or is the presence of emotional and mental strains necessary, along with the bacillus, for the development of the disease? An answer based on a controlled experiment is obviously not possible. But it is now the opinion of most authorities that most of those afflicted with tuberculosis are individuals under greater emotional and mental strains than their personalities can bear. Man

is a thinking, feeling animal. Maladjustment in his emotional and mental life is bound to affect his bodily processes to some degree.

Emotional and psychic factors, however, are not present to the same degree in all cases. The force of the somatic factors represents more than zero percent and may represent up to 100 percent of the cause of tuberculosis in various cases. The force of the psychic factors may represent anywhere from zero to less than 100 percent of the cause in various cases. Somatic factors rarely range to 100 percent with psychic factors at zero percent, although this can and apparently does occur. The present state of our knowledge of disease, and of tuberculosis in particular, permits us to assert no more, and no less. Those concerned with the physical manifestations of tuberculosis must never forget that psychic factors are generally present; those concerned with the psychic causes must always remember that the "bug" is never absent.

The effects of tuberculosis upon personality are more generally understood. Authorities agree that tuberculosis and its long hospital treatment place a strain upon the personality of the sufferers unequalled in most other diseases. Logic and experience support the view that the patient's ability to withstand the strains depends on the strength of his personality at the time of the onset of the disease. The mature, emotionally stable individual will react well. The emotionally unstable or maladjusted person will have more difficulty coping with the problems.

Characteristics of Patients

The effect of tuberculosis upon personality has been described by numerous investigators. Anxiety and fearfulness are almost always found. Neurasthenia, anorexia, fatigue, suggestibility, hypochondriasis, depression, preoccupation with self and irritability are also frequently mentioned. These characteristics of tuberculous patients in no way define *the* specific personality typical of all tuberculous patients at all stages of the disease. Whether or not such characteristics are produced depends on the personality of the patient and his circumstances during hospitalization. The burden of hospitalization for tuberculosis is a heavy one which few can bear without considerable help and support.

The veteran is not different from the non-veteran in the strain tuberculosis puts upon him. Possibly his frustration is more acute because many veterans are admitted to VA hospitals soon after discharge from the military when their eagerness to resume the pleasures of unrestricted civilian life is at its peak. To many of them the VA hospital means a return to hated regimentation, and their anger and resentment are likely to be explosive.

Earlier Studies

In the foregoing discussion, an effort has been made to present the situation confronting the person with tuberculosis who is living the circumscribed life of hospitalization. In order to understand what drives a tuberculous patient to irregular discharge, it is necessary to understand what is driven—the human material with which we are concerned. What, then, are the reasons which have been found responsible for irregular discharge of the tuberculous?

Studies made in the past have suggested several different reasons: financial and family problems, emotional immaturity, fear of surgery, dissatisfaction with treatment. One of the best studies, made by Bobrowitz (*11*, *12*) on 70 patients irregularly discharged from the municipal sanatorium at Otisville, New York, showed that the patients gave 137 different reasons for leaving. Forty-two percent of the reasons were related to personal and emotional problems, 25 percent to the patient's belief that he no longer needed hospital care, 17 percent to dissatisfaction with the sanatorium and 11 percent to dissatisfaction with medical care. The other reasons were miscellaneous.

The Veterans Administration made a comprehensive study of the accomplishments of its tuberculosis hospitals in 1943, with special attention to irregular discharge (*13*). This study presented the reasons for their irregular discharge given by veterans who later went back to hospitals. The stated reasons were not always the real reasons, of course, but in general, the same patterns were evident. Thirty-nine percent said they left for family or financial reasons, 21 percent because of dissatisfaction with hospital rules or treatment, 11 percent because of boredom, 9 percent because they believed they could be as well cared for at home, 7 percent because of reduction in disability compensation or pension, 11 percent for disciplinary reasons and the remaining 2 percent for miscellaneous reasons.

In these earlier studies the answer to the question, "Why do irregular discharges occur?" is given by specialists in medical treatment of tuberculosis, by officials of tuberculosis hospitals, by the patients at the time they are preparing to leave the hospital without medical sanctions, or as above, by patients back in the same hospital or hospital system from which they had previously received an irregular discharge. What do tuberculous veterans think and feel about their irregular discharges, not at the time one foot is already outside the hospital door, when emotion runs high and clouds honest thought, but several months later, in the quiet of their own homes, when sober reflection is more nearly possible? And what do social workers, trained in personal relationships, think are the reasons the veterans left the hospitals irregularly?

Study of July 1947

To answer both of the above questions and to obtain the basic data for constructive remedial action a study was made of irregular discharges of tuberculous veterans from VA hospitals in the month of July 1947. In that month there were 569 irregular discharges of tuberculous veterans from VA hospitals and 658 regular discharges.

Of the 569 irregular discharges in July 1947, 56 percent were absences from the hospital without official leave (AWOL), 38 percent were against medical advice (AMA) and 6 percent were by action of a disciplinary board because of misconduct. During the 12 months of fiscal 1947, 59 percent of the irregular discharges were AWOL, 33 percent AMA and 8 percent disciplinary.

The number of irregular discharges during July 1947, was only one more than the number of different individuals receiving such discharges (568). One veteran twice received irregular discharge during the month. However, 45 percent of the individuals were known to have received previous irregular discharges; 48 percent had not previously been irregularly discharged as VA patients; data for the remaining 7 percent were not available. Of the total number, 19 percent had one previous irregular discharge and 26 percent had more than one. Ten percent of the veterans had histories of 5 or more irregular discharges prior to the irregular discharge of July 1947.

The tuberculous veterans who were irregularly discharged from tuberculosis or general medicine and surgery hospitals of the Veterans Administration during July 1947, were interviewed by trained social workers. The few tuberculous veterans who had been discharged from neuropsychiatry hospitals were excluded from the study because of the special problems of tuberculous among the mentally ill. Discharges by action of disciplinary boards because of misconduct were also excluded because of the special problems involved in such discharges. Of the 568 veterans 533 were therefore to be interviewed (317 with AWOL and 216 with AMA discharges). Completed interview summaries were received from 401 of the 533. Twenty-six of the veterans had died in the 5 months between the date of the irregular discharge and the date of submission of the interview summaries. An additional 106 veterans could not be interviewed for various reasons (could not be found, were too ill, etc.). Only three veterans whose whereabouts were known refused to be interviewed.

The interviews were begun in October 1947, at least 3 months after the irregular discharge. Most of the interviews had been completed by January 1948. The interviews took place at the home of the veteran or at a place designated by him (at a VA regional office, in a few cases, for the veteran's convenience).

Each veteran was interviewed by a professional social worker on the staff of the VA hospital, regional office or center nearest the veteran's place of residence. A social history and hospital summary for each veteran, prepared by the social service unit at the hospital from which he had been discharged, was forwarded to the interviewer before the interview was held. After the interview the social worker filled out a detailed interview summary (see appendix) which was submitted to the central office for tabulation and analysis.

The social workers who conducted the interviews were the most experienced staff members in their departments. Interviewing veterans was their regular daily job and they were chosen for their skill. They were instructed to emphasize to the veteran the fact that his statements and the opinions he expressed in the interview were entirely confidential, and would have no bearing whatsoever on his eligibility for future hospitalization or for disability compensation or pension, and that the sole purpose of the interview was to get facts concerning irregular discharge of the tuberculous. The social workers were also instructed to state their own opinions frankly and freely.

Basic Causes

The basic causes of irregular discharge of the tuberculous, (1) as viewed by the veteran in explaining his own irregular discharge, (2) as the social worker evaluated the situation and (3) as reported in the case records at the hospital, are summarized in table 1. Domestic and family problems and the veteran's dissatisfaction with hospital rules and procedures were among the three most frequent causes of irregular discharge in all three sources. According to the opinion stated in the case record and the opinion formed by the social worker, the immaturity or irresponsibility of the veteran was also among the three most frequent causes of irregular discharge. In the veteran's opinion dissatisfaction with the attitudes of or interest shown by hospital personnel was among the three most frequent causes.

Prior to August 1946, disability pension or compensation problems of the veterans were a frequent cause of irregular discharge. Before the passage of Public Law 662 by the 79th Congress, on August 8, 1946, the pension or compensation of a veteran without dependents was reduced for the period of his hospitalization by the Veterans Administration. The pension (for nonservice-connected disability) was reduced to $8 monthly, and compensation (for service-connected disability) was reduced to $20 a month. Criticism of these provisions was severe. It was alleged that they established a monetary incentive for avoiding needed hospitalization and that they added to the economic pressure upon many hospitalized veterans without dependents.

Table 1. *Percentage distribution of cases by reasons for irregular discharge cited by hospital case record, by veteran and by social worker*

Reason for irregular discharge (in order given on interview summary)	Social worker's evaluation [1]	Opinion of veteran [1]	As stated in case record [2]
Domestic or family problems	26	30	25
Job-employer-financial problems	5	9	7
Disability pension or compensation problems	1	2	1
Dissatisfaction with medical treatment	9	18	9
Dissatisfaction with attitudes of or interest shown by hospital personnel	11	20	2
Dissatisfaction with hospital rules and procedures	12	26	12
Influence or encouragement of persons outside hospital	4	2	1
Immaturity or irresponsibility of veteran	27	2	10
Failure to comprehend seriousness of physical condition	11	5	2
Fear of surgery or other treatment techniques	5	5	5
Feeling of despair, hopelessness about physical condition	7	4	2
Inability to find absorbing activities in hospital	7	10	4
Veteran believed his leaving was not contrary to medical advice	2	4	0
Fear of action by disciplinary board [3]	1	2	7
Veteran believed he could receive proper care at home [3]	3	7	9
Desire to transfer to sanatorium closer to home [3]	2	2	3
Miscellaneous [3]	2	2	1

[1] The figures in these columns represent the number of cases in which the reason was cited, as a percent of the total number of cases interviewed (401). Since either the veteran or the social worker cited more than one reason in some cases, the sums of the figures in the columns for the veterans' and social workers' responses exceed 100 percent.

[2] Data on the reasons for the irregular discharge were lacking in the records for 236 (44 percent) of the total number of veterans to be interviewed (533). The figures in this column for responses based on the case record represent the number of cases in which the reason was cited, as a percent of the total number of cases in which case record data were available (297 of the 533 cases to be interviewed).

[3] Not originally listed in interview summary but added in tabulating because of frequency of occurrence.

The frequency with which pension or compensation problems appeared among causes of irregular discharge in previous studies shows that many veterans resented the former provisions.

Under the new law, pension and compensation payments for a veteran without dependents are reduced by 50 percent to at least $30 a month after 6 months of hospitalization, but the amount of the reduction is merely withheld until the veteran receives a regular discharge from the hospital, when it is paid to him in a lump sum. If the veteran receives an irregular discharge, he must wait 6 months before he receives the amount withheld, but he receives it nevertheless.

According to the opinions of both veterans and social workers, as revealed by the interview summaries, pension or compensation problems are now an insignificant cause of irregular discharge. Undoubtedly there are some veterans who feel that withholding part of their pension or compensation after 6 months of hospitalization constitutes an undue reflection upon their ability to manage their own affairs. It is an open question whether this practice helps the veteran's state

of mind, but there is no evidence that it is of material significance in causing irregular discharge.

The extent to which there was agreement between the veteran's and social worker's opinions of the basic causes of irregular discharge is indicated in table 2.

In each case in which disability pension or compensation problems were cited as a reason by the social worker, the veteran cited the same reason. (There were, of course, other cases in which this reason was cited by the veteran in which it was not cited by the social worker.)

Table 2. *Number and percent of cases in which the reason for irregular discharge cited by the social worker was also cited by the veteran (listed according to reasons for irregular discharge)*

Reason for irregular discharge	Number of cases in which reason was cited by:—		Percent of cases in which veteran agreed with reason cited by social worker
	Social worker [1]	Both veteran and social worker	
Disability pension or compensation problems	3	3	100
Veteran believed his leaving was not contrary to medical advice	8	8	100
Dissatisfaction with medical treatment	38	33	87
Veteran believed he could receive proper care at home	14	12	86
Job-employer-financial problems	22	18	82
Dissatisfaction with hospital rules and procedures	50	40	80
Domestic or family problems	104	81	78
Fear of action by disciplinary board	4	3	75
Dissatisfaction with attitudes of or interest shown by hospital personnel	44	29	66
Fear of surgery or other treatment techniques	22	13	59
Inability to find absorbing activities in hospital	29	17	59
Desire to transfer to sanatorium closer to home	8	4	50
Feeling of despair, hopelessness about physical condition	29	12	41
Influence or encouragement of persons outside hospital	15	5	33
Failure to comprehend seriousness of physical condition	44	10	23
Immaturity or irresponsibility of veteran	108	7	6

[1] Column total exceeds 401 because more than one reason was cited in some cases.

The same was true of the reason "veteran believed his leaving was not contrary to medical advice."

It is, of course, not surprising that veterans believed reasons classified as "immaturity or irresponsibility of veteran" were a basic cause of the irregular discharge in only 6 percent of the 108 cases in which the social worker believed this was a basic cause. In 64 percent of these 108 cases, veterans cited their dissatisfaction with medical treatment, hospital personnel, or with hospital rules and procedures

as causes, and in 36 percent they cited domestic or family problems or job-employer-financial problems.

A general summary of the primary reasons for the irregular discharges is presented in table 3.

According to the veteran's opinion, the pressure of factors originating within the hospital was a cause of the irregular discharge in 79 percent of the cases; factors originating within the personality of the patient were a cause in only 19 percent of the cases. The social worker's evaluation, which is far more objective, disclosed that the three

Table 3. *Percentage distribution of cases by three major categories of reasons for irregular discharge cited by the veteran and by the social worker*

Reason for irregular discharge	Percent[1] of cases in which reason was cited by—	
	Veteran	Social worker
A. Pressure of factors originating outside hospital and related to veteran's personal, social, and economic status. These include domestic or family problems, employment and financial problems, influence of persons outside the hospital, etc	54	43
B. Pressure of factors originating within the hospital, related to the lack of adaptation between the hospital environment and the veteran. These include dissatisfaction with medical treatment, with the attitudes of or interest shown by hospital personnel, or with hospital rules and procedures; inability to find absorbing activities within hospital; etc	79	42
C. Pressure of factors originating within the personality of the veteran and related to a sense of inadequacy, insecurity, or lack of understanding. These include immaturity or irresponsibility of veteran; failure to comprehend seriousness of physical condition; fear of surgery or other treatment techniques; etc	19	51

[1] Column total exceeds 100 percent because more than one reason was cited in some cases.

types of reasons are at the root of irregular discharge in almost equal degree, with the pressure of factors originating within the personality of the veteran as a cause in somewhat more cases than either of the other reasons.

Preventive Measures

The data concerning actions that might be taken within the existing framework of VA operations to prevent irregular discharge are not conclusive, because of the varying policies of VA hospitals. Some of the data are significant nevertheless.

Specific actions within the existing framework of VA operations that *might* have prevented the irregular discharge were mentioned by the social worker in 282 or 70 percent of the cases. In the remaining 30 percent the social workers believed that irregular discharges could

not have been prevented by VA personnel or that they could have been prevented only by material change in VA's methods of operation.

Intensive social case work with the veteran and his family, both during the period of the veteran's hospitalization and prior to his hospital admission was urged as a preventive measure in more than half of the cases in which social workers suggested specific steps that might have prevented the irregular discharge. Psychiatric treatment for the veteran, awareness on the part of hospital staffs of the emotional factors in tuberculosis, and more personalized treatment by the medical staff were mentioned in approximately 20 percent of these 282 cases. More careful and considerate application of hospital rules, mentioned in 17 percent of these cases, covered such matters as separation of negative sputum from positive sputum cases, ward arrangements, ground privileges and assignment to specialized tuberculosis hospitals or wards. More sympathetic or more discriminating application of pass privileges was suggested in 15 percent of the cases. Routine AWOL discharges issued upon a veteran's failure to return to the hospital before the expiration of his leave were deplored in several cases. Social workers felt that more intensive or varied rehabilitation and recreation, better adapted to the individual needs and interests of patients, might have been effective in preventing irregular discharge in 11 percent of the cases.

In 27 percent of all cases, the veterans themselves expressed the opinion that nothing VA might have done would have prevented the irregular discharge. The social workers agreed in approximately one-third of these cases; in another third the social workers believed that intensive social case-work services with the veteran and his family might have been effective in preventing the irregular discharge; and in the remaining cases the social workers believed that other steps might have brought results.

Of the cases in which the veterans felt that VA measures might have prevented the irregular discharge (293 or 73 percent of all cases), improvements in the medical service received by patients were mentioned in 46 percent of the cases. Veterans cited need for increased medical staff, more personal attention from doctors and nurses, and more time given by the doctor to discussing the patient's condition with him. In 39 percent of the 293 cases, need for improvements in the hospital service was mentioned—such matters as separation of active from inactive cases, less delay in observation and examination, need for a quiet place for bed rest, hospitalization closer to home. Improvement in the quality of food was cited in only 7 percent of the cases. In 26 percent of the cases, veterans felt that a more liberal pass policy was needed. Greater recreational or diversional opportunities were mentioned in 9 percent of the cases.

In about one-third of the cases in which the veteran cited need for improvements in medical service, social workers had expressed the opinion that more personalized consideration by the medical staff might have prevented irregular discharge. Social workers believed that more considerate application of hospital rules might have been effective in about one-third of these cases.

The following generalizations are based on an analysis of the 204 cases in which the social worker felt that the action which might have prevented irregular discharge was not possible within the existing framework of VA operations or was possible to only a limited degree. In a third of these 204 cases, there were not enough social workers to provide effective case work for the tuberculous veteran and his family. Psychiatric treatment when indicated, or education of personnel to an understanding of the emotional components of tuberculosis, was considered inadequate in 22 percent of the cases. The establishment or reconsideration of hospital rules and procedures was recommended in 40 percent of the 204 cases. These rules and procedures covered such matters as reception and orientation of the patient upon admission to the hospital, assignment to wards, bed arrangements, punishments for infraction of rules, availability of vocational, rehabilitative, or recreational activities, cooperation between doctors and auxiliary medical personnel, and consideration of patients' complaints and dissatisfaction. Reconsideration of pass privileges and leaves of absence was indicated in 16 percent of these cases. The development of a scheme for tuberculous patients to make "trial visits" to their homes and provision for a more thorough review of the patient's explanation in AWOL cases were recommended in a number of instances. Hospitalization of tuberculous veterans in separate tuberculosis hospitals or wards, transfers of patients to hospitals closer to their homes, and other practices related to hospital assignments were mentioned in 13 percent of the cases.

A Social Problem

The repeated emphasis upon the significance of the social and psychological factors in treatment of tuberculosis cannot be dismissed as part of a plot by social workers to enhance their own prestige.

Irregular discharge is a problem that is definitely related to the long treatment necessary in tuberculosis. It will continue to be a problem until vastly simpler and speedier methods of cure are developed. But we must remember that the subject of treatment for tuberculosis is the patient, not the disease. To the extent that we treat the patient—a human being with hopes and fears, hates and loves, with a family, friends, a job—we also treat the conditions that give rise to irregular discharge.

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As noted earlier, affliction with tuberculosis and hospitalization for treatment place a great strain upon the human personality—not only upon the lungs but upon the emotional and mental aspects of personality as well. If the personality is strong or well-supported, the patient can withstand the influences within the hospital and the pressures from without that drive him out of the hospital before treatment is completed. If the personality is not strong or is not supported, or if the influences and pressures from within and outside the hospital are overwhelming, the patient will walk out on irregular discharge.

As Dr. Canby Robinson has expressed it, irregular discharge of the tuberculous occurs because the patient is "pushed out or pulled out" of the hospital. Treatment of the tuberculous patient is a cooperative undertaking which requires the joint effort of doctor, nurse, psychologist, social worker, rehabilitation expert, and special services specialist.[6] To reduce the effectiveness of any member of this team is to increase the likelihood of irregular discharge.

The prevention of irregular discharge begins at the start of treatment. And treatment begins when the patient is first informed that he has tuberculosis. Explanation of the diagnosis is of vital importance because the patient's initial reactions quickly harden into a pattern that influences all his later attitudes and reactions (*14*). Riley describes the moment when the doctor acquaints the patient with the diagnosis as the "psychological" moment. "The foundation for successful treatment in tuberculosis is laid when the doctor tells the patient that he has the disease. Psychologically, medically, and economically, this may well prove to be the biggest moment in the patient's life" (*15*).

The emotional shock or "psychological blackout" that occurs when a patient is told that he has tuberculosis is well known (*16*, *17*). Explanation of the diagnosis cannot be a routine affair, since patients do not all react alike. The patient cannot be hurried. Unless he is given an opportunity to express his fears and anxieties, tensions will be stored up to generate future difficulties. The flame that bursts out into irregular discharge is often kindled at the time the diagnosis is revealed. "A healthy adjustment in the hospital implies a psychological awareness and acceptance of the illness. When the acceptance has not been achieved, the patient rejects the hospital as a symbol of the disease" (*18*).

The responsibility of the doctor in enabling the patient to gain psychological acceptance of the diagnosis cannot be too strongly emphasized. The understanding and assurance the patient receives

[6] The term "special services specialist" refers to the chaplain, librarian, recreation worker, and canteen worker.

from his doctor are far more important in creating a frame of mind conducive to successful hospitalization than any help the patient receives from others. The diagnostician who displays a genuine concern for the patient as a person—who recognizes and takes an active interest in his emotional, psychological, and social problems, as well as in his physical condition—will make hospitalization an easier experience for the patient and an easier task for the doctors who will subsequently treat him.

Half the battle is won when the doctor takes the time to explain to the patient the nature of his illness, the treatment plan as it applies to the patient's individual circumstances, and the help available to him in dealing with the problems caused by hospitalization. True, the diagnostician is generally unable to devote time to all the problems involved. For this he needs the help of the medical social worker. But he must explain to the patient how the medical social worker can help. The responsibility remains the physician's and the process of enabling the patient to gain psychological acceptance of the diagnosis is begun by him. All else that follows is supplementary. His efforts are basic.

In the interval between diagnosis and hospital admission the patient must be psychologically and emotionally prepared for hospitalization. The more help he receives during this crucial period, the less help he is likely to require during hospitalization. Social case work with the patient and his family during this period is not only desirable but essential.

The family's reaction and attitudes toward the patient's tuberculosis can have a decided effect upon the progress of his treatment. The members of the family, as well as the patient, need education as to the meaning of the disease. They must be made particularly aware of their part in enabling the patient to remain in the hospital until treatment is completed. Their way of life and standard of living may be threatened by the patient's illness. They as well as the patient may experience psychic shock when the diagnosis is made known and they too may require psychotherapy.

The nurse also plays a vital role in helping the patient in his psychological and emotional preparation for hospitalization. Both in what she tells the patient and in her attitude toward the patient as a person, the nurse can be instrumental in laying the foundation for a successful hospitalization. Especially during the course of teaching the patient protective measures for himself and his family, the nurse has the opportunity of strengthening the patient's attitude.

Irregular discharge is seldom the result of a sudden whim or the byproduct of circumstances first created within the hospital. As Quinn has remarked it is more often "a climax to a long series of life

experience" (*19*). We must therefore recognize the futility of waiting until the patient is on the brink of irregular discharge before actively seeking to deal with the problems that trouble him. Patients who are "demanding," "obstreperous," "trouble-makers," "uncooperative," are often wrestling with deep-seated emotional problems. Because of the scarcity of qualified personnel, psychiatric consultation for each tuberculous patient whose difficulties require it cannot be provided at present. And yet, if we are to prevent irregular discharge, we must not wait until the patient's tensions have reached the explosion point before we try to help him. When worry, fear, and resentment have already mounted and the veteran has made up his mind to quit, the hospital is on the defensive. What it then undertakes to prevent the irregular discharge may merely reinforce the veteran's determination to leave. A systematic offensive against the potential causes of irregular discharge in the case of each individual tuberculous patient must be begun soon after he is admitted to the hospital and must be a continuation of the case-work service that has preceded hospitalization.

This does not mean offering services that are not wanted. It does mean an awareness and a searching out of problems where they are likely to exist. The initiative lies with the hospital personnel, not the veteran. It is unreal to insist that the veteran's problems become the concern of the hospital staff only when he brings them to the staff. The fact that he is a patient in the hospital makes his problems their concern from the moment he is admitted.

Yet a cardinal principle that applies to the tuberculous veteran as it applies to any person who needs help, is the recognition of his right to maintain active control in planning his own life. To treat the patient as a person is to recognize his right to become discouraged, impatient, even unreasonable, as any family member may sometimes become unreasonable, and yet patiently to give him help in mastering these attitudes. There are great psychological advantages in allowing a patient to be an active agent in his own treatment and in helping him to meet his own problems.

Attacking the Problem

The problem of irregular discharge of the tuberculous is not going to be solved overnight. There is no magic formula or set of "steps" that can be applied all at once to eliminate it. It is a problem which requires careful, long-range planning, and, most important of all, direct action based on what is already known. It is not within the province of this study to detail specific administrative regulations and procedures designed to solve the problem. There are, however, certain basic considerations which should be noted.

Withholding disability pension or compensation—The existing legal provisions for payments of disability pension or compensation to hospitalized veterans without dependents represent a great advance over those they superseded. Now these payments are not cancelled after 6 months of hospitalization, but are merely withheld in part. The question is raised, however, whether the payments should be withheld at all and whether the end achieved justifies all the bookkeeping involved. Withholding part of the payments may make the veteran feel that his right to direct his own affairs is being infringed and may subject him to a system of "compulsory saving" which exaggerates his dependency. On the other hand, the provision applies only to veterans who, while hospitalized, are receiving food, shelter, and other subsistence items without charge, and who have no persons dependent upon them for support. The lump sum accumulated is made available to the veteran upon his discharge from the hospital and represents an essential resource for his return to normal community living. Only a small number of veterans attribute their irregular discharge to withheld pension or compensation payment. In any event, the present procedure is required by law. It may be appropriate to reconsider the advantages of the present procedure in the light of the questions that are raised.

Hospitalization exclusion period for veterans with irregular discharge—Any veteran who receives an irregular discharge from a VA hospital is denied the right to subsequent rehospitalization for a period of 90 days, except in cases of emergency. This provision has been frequently criticized, particularly by the authorities of community (non-VA) hospitals. They say it punishes the community more than it does the veteran. Denied the right to rehospitalization by VA, the veteran may merely be free during his "cooling-off period" to spread his disease or he may be hospitalized by the community in a non-VA hospital. As a preventive measure, the provision has had little effectiveness. Veterans do not refrain from actions leading to the irregular discharge because they fear denial of rehospitalization at a later date. They refrain from actions leading to irregular discharge because they are free of the tensions, disturbances, and anxieties which are at the root of irregular discharge.

On the other hand, it is a protection for patients in the hospital who are entitled to an orderly and quiet atmosphere free of the disturbance and disorder created by patients who fail to abide by the rules. Otherwise, there might be more irregular discharges, for other patients would leave because they could not obtain rest and quiet in the hospital.

It may be advisable to re-examine the exclusion provision in the light of the problems it creates for the community. But the VA hospital's primary duty to seek the greatest good for the greatest number of its patients must also be safeguarded.

Compulsory hospitalization for open cases of tuberculosis—There are and there will continue to be some cases in which compulsory hospitalization appears to be the only way of protecting the community from the veteran and the veteran from himself. This is a question which the Veterans' Administration must meet, but VA cannot endorse any practice which applies to veterans only and which treats tuberculous veterans differently from tuberculous non-veterans. The question of compulsory hospitalization of persons with open cases of tuberculosis who constitute a public health menace is nation-wide and calls for a national solution. A system which is in effect in some States only, is bound to break down. The problem is stated here not because it is one for solution by VA, but because VA is interested in cooperative planning by the health departments of all the States, insofar as they affect veterans as community members with obligations as well as rights.

Financial aid for families of the tuberculous—Compulsory hospitalization for open cases of tuberculosis, and even voluntary hospitalization are almost a contradiction in terms, without adequate financial provisions for needy families of the tuberculous. There are special Federal provisions for the aged, the blind, and for dependent children, but the families of the tuberculous are included in the undifferentiated category for whom general relief is provided by the States or counties. In some States, families of the tuberculous which include young children are granted "aid to dependent children." Numerous studies have shown that general relief grants do not fulfill the provisions in the State laws that relief shall be granted to enable families to maintain a "decent and healthful" standard of living. Here again, the problem is beyond the province of VA, but is one in which VA has a legitimate concern, particularly because the veteran hospitalized for nonservice-connected tuberculosis receives no disability compensation. His family may lack adequate food, clothing, and shelter.[7]

Re-definition of discharges "against medical advice"—It is clear from the comments which have been received from the field on a proposed revision of the concept "against medical advice" that VA hospitals do not all understand this term in the same sense. Certain types of discharge have been classified as "against medical advice" by some VA hospitals and as regular discharges with maximum hospitaliza-

[7] Compensation provided by the Veterans Administration for veterans with service-connected tuberculosis has again been liberalized by Congressional action. Heretofore the amount of the compensation has been based on degree of disability. Under Public Law 877, recently enacted by the 80th Congress, veterans whose disabilities are rated 60 percent or more in degree will receive additional allowances for a wife, child, and dependent parent. In many States, however, compensation received by a veteran whose family is in need of public assistance is considered "family income," and the amount of assistance the family would otherwise receive is reduced by the amount of the compensation. Some States permit the compensation to be used, in whole or in part, for special needs of a tuberculous veteran or of his family, without reduction of the assistance grant by the total amount of the compensation.

tion benefits by others. Indeed, differences in irregular discharge rates of VA hospitals may be partly explainable on this basis. The confusion arises from the fact that the concept "against medical advice" does not represent a judgment on medical matters solely, but also implies an evaluation of matters that are distinctly social in nature. Surely there should be a difference between (1) the discharge given a veteran with far advanced active tuberculosis who wishes to leave the VA hospital when there is conclusive evidence that he will enter a non-VA hospital closer to his home, and (2) that given a veteran with minimal tuberculosis who states that he can receive proper care at home when there is no evidence that home care in his case will be suitable. The two situations are so different that it would appear illogical to include them in the same category. As a first step, therefore, clarification of terms must be undertaken.

The doctors must *know* that the veteran's care will be adequate after he leaves the VA hospital. And this they cannot know without a social investigation completed before the veteran is to leave. There are some tuberculous patients for whom home care is totally proper and even preferable. In a few of the cases analyzed, it was evident from the information contained in the interview summary that nothing was lost by the veteran's irregular discharge. He was much happier at home, was receiving proper care from members of his family and adequate medical attention from the family physician, and was in no way jeopardizing the health of others.

If the VA doctor knows that a particular veteran requesting discharge will receive proper care at home, and if no local health law is violated, it should be unnecessary to discharge the veteran "against medical advice," even though he still requires positive treatment for tuberculosis. Such a veteran should not receive an irregular discharge. He should not receive a regular discharge either. That classification should be reserved for patients who, from a purely medical standpoint, no longer require hospital care and treatment, or who are legally ineligible for hospitalization by VA. He should receive a "conditional discharge," a category distinct from regular and irregular discharges.[8]

A veteran requesting discharge who leaves before an evaluation can be made of the environment in which he will be living following departure from the hospital, or a veteran who is determined to leave even though such an evaluation has shown that the environment is unsuitable for the care he requires—should receive a discharge "against advice," not a discharge against *medical* advice. In other

[8] Use of the term "conditional discharge" is not meant to imply that the discharge must be converted to a regular or irregular discharge at a later date.

words, the situations to which discharges against medical advice have heretofore been applied have involved action contrary to both medical advice and social advice. If the action is not contrary to social advice, it should not be called an irregular discharge. If it is contrary to social advice, it should be called a discharge "against advice." The designation "discharge against medical advice" should be abolished, since the situation to which it has been applied inevitably involves more than an evaluation of medical matters alone.

The following classification of hospital dispositions of patients is therefore proposed (a disposition means any separation of a patient from a hospital):

I. Discharges
  A. Regular
    1. Maximum benefits of hospitalization
    2. Terminal condition
    3. Observation completed
    4. No hospital care needed
    5. Ineligible for VA hospitalization
  B. Conditional
    1. Suitability of home treatment established
    2. Transfer to non-VA institution verified
  C. Irregular
    1. AWOL
    2. Against advice
    3. Disciplinary
II. Transferred as VA patient
  A. To VA hospital
  B. To VA home
  C. To non-VA hospital
III. Died

Discharges, transfers, and deaths are types of dispositions. Discharges are regular, conditional, or irregular. Regular discharges involve judgment on medical matters solely—the patient no longer requires medical treatment in a hospital (or, in a few cases involving judgment on legal matters, the patient is ineligible for hospital care by VA). Conditional discharges involve judgments on medical and social matters—in view of the patient's condition, the environment to which he will move after leaving the hospital has been found suitable for the care he requires. Irregular discharge is the contrary of both regular and conditional discharges. It recognizes that the patient still requires hospital treatment but has gone AWOL. Or the patient leaves in spite of the finding that the environment to which he wishes

to move is unsuitable for the care he requires, or before an investigation can be made. Or the patient must be expelled from the hospital because of his conduct.

In short, when a patient who still requires treatment first expresses an intention to leave the hospital, a study should be conducted by the social service unit of the station serving the area which includes the veteran's proposed destination (the veteran's home, a private or another public hospital, etc.). From data obtained in such a study and his medical knowledge of the veteran's condition, the VA hospital doctor can decide whether the patient's leaving must be disapproved (discharge "against advice") or may be approved conditionally ("conditional discharge").

The study conducted by the social worker must include a review of the veteran's proposed plan in the light of public health provisions in effect in the locality of the veteran's proposed destination. If the local public health officer cannot legally sanction home care for a particular veteran, a conditional discharge may not be granted by the VA hospital, since it would contravene the judgment of a public authority. If a veteran refused to wait until the social study is completed and leaves, a discharge "against advice" must be granted since complete medico-social data are lacking and the doctor cannot make a conditional judgment.

Strengthening of patient-doctor relationship—The patient-doctor relationship—the doctor's genuine interest in the individual patient as a person, and the patient's confidence in the doctor as someone who sincerely recognizes his total interests—is the Rock of Gibraltar in treatment of tuberculosis. The doctor who allows himself to develop "routinitis" in his relationship with tuberculous patients forgets that tuberculosis is a unique experience for the patient, even though it is a common enough phenomenon to the doctor. The doctor who stops at the patient's lungs, who fails to reach out and learn what goes on in his head and heart, is missing one of the most challenging and rewarding experiences man can have. All other measures designed to prevent irregular discharge of the tuberculous pale into insignificance without a sound and whole-hearted patient-doctor relationship. There is no substitute. It comes first and it remains basic throughout treatment. It is the *sine qua non* that validates and reifies everything that anyone else does to prevent irregular discharge.

The writer was informed of the record at one public sanatorium where the chief medical officer made it his business to know his patients as individual personalities and to give them assurance that their emotional and social problems, as well as their physical conditions, were his concern. The irregular discharge rate at this sanatorium was low. During his absence for a period of several years, the irregular dis-

charge rate more than doubled. When he returned, the irregular discharge rate was drastically reduced. When he again left the sanatorium, the irregular discharge rate increased as drastically as it had previously been reduced. There was no magic in this doctor's treatment. By his own attitudes and actions he enabled the patients to see that leaving the sanatorium before treatment was completed was unnecessary and a violation of a trust they had established with him and with themselves.

VA must therefore develop ways to enable doctors—VA doctors in hospitals and regional office clinics, and private doctors examining patients, at the request of VA, in their own offices—to establish a stronger and more effective relationship with their tuberculous patients. Patients in VA hospitals who receive understanding and assurance from the doctors who examine and treat them have the strongest possible support for successful hospitalization.

Utilization of medical social service at time of diagnosis and during period prior to hospital admission—In the period between diagnosis and hospitalization the medical social worker may well be called in by the doctor to help explain the disease to the veteran, to give him further opportunity to verbalize his feelings about the difficult and painful situation confronting him, and to continue building up the supports he will need during his hospitalization. The family as well as the veteran should be the worker's concern. Time and labor thus spent will prove their value months later at the VA hospital with a veteran whose emotional and mental states are conducive to completion of hospital treatment.

It may be necessary to re-examine the concept of "treatment" for veterans whose tuberculosis is nonservice-connected and who have been declared eligible for hospitalization by VA. The law provides that, in general, outpatient medical care shall be available only to veterans with service-connected disabilities. Social service, however, should be viewed as an integral part of hospital treatment. It is extramural, to be sure, but it is not in the same category as the outpatient care received by an individual who needs no hospitalization. A tuberculous veteran who has been determined eligible for hospitalization by VA and who is awaiting hospital admission should receive the social service that will enable him to remain in the hospital until treatment is completed. Since such service cannot be provided by VA under existing interpretations of the law, they must be provided by the community. But VA social service units can establish working relationships with existing community agencies to help develop proper facilities.

Patient orientation after hospital admission—Orientation of the patient when he enters the hospital means more than an explanation of visiting hours or the procedure for checking clothing. The best of hospitals is still an alien environment for the best of patients. The character of the patient's departure from the hospital may be influenced in large part by the nature of his reception. The tuberculous patient entering a hospital needs understanding not only of the physical conditions affecting his hospitalization (location of wards and departments, ward routines, etc.), but also of the nature of tuberculosis as a disease and the basic aims of hospitalization for treatment of such a disease, the patient's responsibility in achieving these aims, and the degree to which the tuberculous can be rehabilitated and restored to normal living.

Patient orientation at the hospital is one phase of the continuous process of patient education. It is not accomplished on the first day of hospitalization. Only a beginning can be made on the first day, which is a trying time for the patient even under most favorable circumstances. He should not be loaded with more instructions, advice, and pamphlets than he can bear. It takes days before the patient can find his bearings in the transition from the outside world to the hospital environment, and his orientation must therefore be geared to the tempo of his reactions. An informed patient who knows what hospitalization for tuberculosis means, what he may expect, what he himself must do, is more likely to endure the hospitalization period than one who knows only that he is in the hospital because he has tuberculosis.

Ideally, the patient-orientation program should be directed by a physician with the rare combination of the skills and knowledge of the doctor, nurse, psychologist, social worker, rehabilitation specialist, and special services specialist. Responsibility for the program cannot be made an "additional duty" for someone assigned primarily to something else, nor can it be delegated to the novice who is not yet ready for something "more important." Until patient orientation becomes a specific field with well-defined requirements, responsibility for the program should be assigned to the staff member most capable of coordinating the knowledge and skill in the several fields upon which patient orientation must draw. In any event, the program should be carried out under close medical supervision.

Psychiatric service for tuberculous patients—An understanding of the personality of the tuberculous patient, which is a necessary element in understanding *his* tuberculosis, cannot, as Weiss points out, be obtained simply by a negative reply to the question, "Are you worried about anything?" (*20*). Not all tuberculous patients require psychiatric treatment. According to Bobrowitz, however, all tuberculous

patients would benefit from psychiatric study at the time of admission. The "trouble maker" may be in obvious need of psychiatric treatment, but it is wasteful to wait until the trouble has been made before aid is provided. The establishment of a well-rounded psychiatric service in all VA tuberculosis hospitals or the provision of psychiatric consultation requires serious consideration.

In this connection, it must be emphasized that even if psychiatric service is available, the rest of the medical staff is not relieved of the obligation to take account of the patient's emotional and psychological reactions. It would indeed be unfortunate if other medical staff members assumed that they could go about their "regular" duties and leave consideration of the personality of the patient to the psychiatrist. Intelligent and sympathetic understanding of the complex factors operating within each patient is as "regular" as anything the medical staff does. Psychiatric service for tuberculous patients is additional to, not a substitute for, a genuine regard for the patient as a person on the part of each staff member involved in his medical treatment.

Increased utilization of physical medicine and vocational rehabilitation measures—There are few activities that can be so deadly as "passing the time." There is nothing so fruitless as activity for the sake of activity. Veterans are not children and they are no more interested in play than any other group of adults. Purely diversional therapies can have little meaning unless they are somehow related to the patient's life goals. Measures intended to rehabilitate the veteran must give him a satisfaction beyond that derived from making knick-knacks or pretty things. The satisfaction must be related to something meaningful to the veteran in the outside world, or he will soon lose interest. There is, of course, a limit to bringing the outside world into the hospital. Measures are now available, however, to serve as a bridge between the hospital environment and the outside world.

The primary function of physical medicine rehabilitation is to speed the veteran's recovery from his illness. Its great value lies in the fact that, by keeping alive the veteran's skills and abilities or in developing new skills within the veteran's capacities, it helps him get well by stimulating his will to recover. It has great psychological value in providing for constructive use of the patient's time, within medically controlled limits and in a manner that has meaning in terms of his life goals and interests. Physical medicine rehabilitation endeavors to fill the void which hospitalization has meant to the tuberculous in the past. It helps the veteran see his hospitalization not as a period of dependency, but as an opportunity for achieving new adjustment to the world outside. It sustains the patient's physical and intellec-

tual powers and prevents deterioration. It contains an implicit promise of recovery that makes the patient want to get well. When the will to recover is active, the patient is not likely to be led to irregular discharge.

In brief, then, a tuberculosis hospital must not be a complete retreat from the everyday world. In addition to being a place of rest, it must also be the place where the tuberculous patient, by actual doing, begins the process of social readaptation which his illness has made necessary. The doctor in a tuberculosis hospital who fails to understand the significance of these measures and who is unenthusiastic in encouraging patients to participate in them, makes his own task all the more difficult.

Vocational rehabilitation is the logical sequel to physical medicine rehabilitation. The latter stimulates the development and determines the limits of the patient's capacities. The former seeks to match these capacities with the fields in which vocational opportunities exist. The vocational adviser, with his special knowledge of the prevailing opportunities and needs in the economic world also helps to create for the veteran the bridge between hospital environment and the world outside. He should begin to work with the tuberculous patient not when the patient is ready to leave the hospital, but soon after he is admitted. The sooner a tuberculous patient begins to think of economic opportunities for which he can prepare during hospitalization, the stronger his desire to complete the hospitalization is likely to become.

More effective utilization by doctor of hospital social service for patients—The doctor cannot fully understand the personality of the patient apart from his home, family, job, and the whole complex of his interpersonal relationships beyond the walls of the hospital. VA social service units provide these background data. It is the responsibility of the doctor to recognize their significance and to make use of them in his total treatment plan for the patient.

In many cases he can call to a full extent upon social service to help overcome the personal and social problems that thwart the patient's progress.

Cooperation between regional office and hospital social service units—It is not too much to urge hospital personnel to regard each patient as a potential candidate for irregular discharge. In time, those who need help become distinguished from those who can take hospitalization without outside help. For those who need help, the scope of social service activity extends beyond the hospital to the veteran's home, located perhaps hundreds of miles from the hospital. Every hospital social service case must be at the same time a regional office social service case. The responsibility of the regional office cannot end at the hospital door. Veterans headed for irregular discharge need more

than good cheer and a chance to talk things out. They need help in obtaining hospitalization for a sick child, help in getting the rent paid, help in maintaining their role in the family without being called upon to assume all the responsibilities, and a thousand and one other things that require doing and acting. These things generally cannot be accomplished by the hospital social workers directly, since they are too far from the scene of action. Few VA hospitals are "neighborhood" hospitals. It is important, therefore, that the regional office social service units be strengthened to enable them to work cooperatively with the social service units in the hospitals, so that an integrated and inclusive approach to the veteran's problems can be developed.

Development of a modified "trial visit" program for tuberculous patients—It is easy to exaggerate the significance of passes because the consequence of denial of a pass may be so dramatic and violent. The best and most liberal pass policy can never replace understanding and treating the patient as a person. The manager of one VA tuberculosis hospital, with more than ordinary sensitivity to the nature of tuberculous patients and with genuine insight into the meaning and significance of irregular discharge, adopted a strict policy in the matter of leaves but found no subsequent increase in the irregular discharge rate of his hospital. Passes and leaves, nonetheless, do constitute a difficult problem. It is perhaps a rare patient who believes that the doctor refuses a pass, not because doctors enjoy depriving patients, but from a genuine concern for a patient's well-being. Many a VA doctor must have wondered whether denial of leave serves any real purpose when the patient cannot be compelled to remain in the hospital anyway.

Perhaps trial visits away from the hospital may be advisable. If a veteran's problems are already familiar to the social service staff at the hospital and at the regional office (following the recommendations outlined above), if leave seems essential to the veteran, and the doctor knows from the data which the hospital social service unit has that the veteran can observe proper hygienic precautions and that his condition will not be jeopardized—under these circumstances a "trial leave" might well be approved by the doctor. Such a system presupposes fore-knowledge of the veteran and his problems, i. e., it presupposes continuous case-work contact with the veteran and his family before and during his hospitalization.

Utilization of special services for tuberculous patients—Special services should be helpful in overcoming the lack of adaptation between the hospital environment and the patient, which is one of the basic causes of irregular discharge. Tuberculous patients, like other people, cannot live by work and hope alone. Special services personnel have their part to play in maintaining patient morale, by helping to create

in the hospital an environment conducive to completed hospitalization.

The interest and support available through the hospital volunteers and the voluntary service committees represent a valuable asset which should be used to the full in helping the patient maintain contact with the world outside. Through them and the organizations they represent, an understanding of the nature of the problems created by hospitalization for tuberculosis and the community's responsibilities in resolving these problems can be transmitted directly to the community itself.

Recognition of the cooperative nature of hospital treatment for tuberculosis—A comprehensive plan for hospital treatment of tuberculosis requires the effort of a team of experts. The doctor is the strongest member of that team. By consideration of the patient as a person, he can pull more weight than any other member of the team. But with the combined effort of the other members, he can pull still more. Each has a contribution to make. The nurse, psychologist, social worker, rehabilitation specialist, and special services specialist—each has a unique function.

In conclusion, let it be said that the problem of irregular discharge of the tuberculous confronting VA is part of the same problem confronting the community at large. VA by itself cannot solve the problem even for veterans. Community social and health agencies, including local and State tuberculosis associations and veterans' organizations, must help. VA hospitals with all the staff and material resources obtainable cannot prevent the damages and deficiencies that are a byproduct of our modern way of life, nor can they alone supply the remedy for our social inadequacies. VA must deal with the veteran as it finds him. There is much that VA has already done: witness the declining over-all irregular discharge rate of tuberculous patients in VA hospitals.[9] There is much more that remains to be done. It is not enough that the rate has been declining. Every veteran who leaves a hospital before his treatment is completed represents a challenge to our skill, our knowledge, and our ingenuity. Every irregular discharge should be regarded as a confession of our failure, even though we know that some irregular discharges are beyond our help.

To defeat irregular discharge of the tuberculous will not cost the community more money than it is now spending. The community is already spending more than it would cost to eliminate irregular discharge by paying for hospitalization of individuals to whom the disease has been spread, for re-hospitalization of patients in deteriorated condition, and for the human values and works that have been lost be-

[9] Data which have just become available show that the rate had declined to 42 percent for January 1948, and to 39 percent for February 1948.

cause of incomplete hospitalization. The community pays for today's irregular discharges tomorrow, but it pays nonetheless. It should be possible to convince the community that more spent today to prevent irregular discharge will mean less that must be spent tomorrow. That is the task, one of the most difficult tasks, of administration of medical care.

VA can perhaps point the way by demonstrating what can be done with the resources at hand.

Summary

Although the over-all irregular discharge rate of tuberculous patients in VA hospitals was 54 percent during fiscal year 1947, the problem of irregular discharge of the tuberculous is not peculiar to Veterans Administration. It concerns veterans and nonveterans, VA hospitals and non-VA hospitals alike. To understand irregular discharge of the tuberculous, we must understand tuberculosis as a disease, the tuberculous as patients and as personalities, and hospitalization for tuberculosis as a unique life experience.

In order to study the reasons for irregular discharges, tuberculous veterans who received irregular discharge from VA hospitals during July 1947 were interviewed by VA social workers on the staff of the hospital or regional office nearest the veterans' homes. The interviews were held at least 3 months after the irregular discharge. Unlike earlier studies of the causes of irregular discharge, this study was made to determine the causes (1) as viewed by the veterans themselves several months after irregular discharge, when feeling is less likely to color reflective thought, and (2) as viewed by workers experienced in dealing with problems of personal relationships who would have no reason to regard the irregular discharges as a reflection upon their own professional competence.

The social workers' evaluations disclosed that a basic cause of the irregular discharge in 43 percent of the cases was the pressure of factors originating outside the hospital and related to the veteran's personal, social, and economic status as a member of a family and of the community. In the opinion of veterans this was a cause of the irregular discharge in 54 percent of the cases. The pressure of factors originating within the hospital and related to the lack of adaptation between the hospital environment and the veteran as a patient were found to be a cause, in the social workers' evaluations, in 42 percent of the cases; as against 79 percent in the veterans' judgment. According to the social workers' evaluation, the pressure of factors originating within the personality of the veteran and related to a sense of inadequacy, insecurity, or lack of understanding, was a cause of the irregular discharge in 51 percent of the cases, while veterans recognized these factors as causes in only 19 percent of the cases.

Measures most frequently mentioned by social workers as those which might have been effective in preventing the irregular discharge were: (1) intensive case work with the veteran and his family during and prior to the period of hospitalization; (2) psychiatric treatment for the veteran or orientation of the staff to an awareness of the emotional and psychic concomitants of tuberculosis; (3) more personalized treatment by the medical staff, and (4) more considerate application of hospital rules and procedures governing hospitalization.

Some of the basic considerations for VA in planning to solve the problem of irregular discharge are: (1) redefinition of discharges "against medical advice," in recognition of the fact that judgments on social as well as medical matters are involved; (2) strengthening the patient-doctor relationship, which is the foundation in treatment of tuberculosis, and to which all else is supplementary; (3) utilization of medical social service at the time of diagnosis and during the period prior to hospitalization, to strengthen the patient's ability to endure the trying experience of hospitalization; (4) patient orientation at the hospital to enable the veteran to make the transition from the outside world to the hospital environment under constructive auspices; (5) psychiatric service in tuberculosis hospitals or psychiatric consultation for tuberculous patients; (6) increased utilization of physical medicine and vocational rehabilitation measures; (7) more effective utilization by the doctor of hospital social service for patients; (8) greater cooperation between the regional office and the hospital social service units in order to develop an inclusive approach to the veteran's problems; (9) development of a medically supervised "trial visit" program for tuberculous patients, in an attempt to solve the vexatious problem of passes and leaves; (10) utilization of special services for tuberculous patients, and (11) recognition of the cooperative nature of hospital treatment for tuberculosis.

VA cannot by itself solve the problem of irregular discharge of tuberculous veterans since it is basically social and a problem for the community at large. Failure to seek a solution is costing the community more than the expense of preventing and eliminating irregular discharge.

Whoever can persuade the community of this fact will serve not only the tuberculous but every other citizen as well.

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APPENDIX

Interview Summary

(Place an "X" in the appropriate space where more than one possible answer appears. Use item 65 when additional space is required.)

A. Identifying and Background Information

1. Name of veteran:
2. Address:
3. Age at time of hospital discharge:_____ 4. C-number:_____
5. Veteran of: __WWII; __WWI; __Other 6. Marital status:_____
7. Race:___ White; ___ Negro; ___ Other 8. Discharged:___AMA;___AWOL
9. Service-connected for TB: ___ Yes; ___ No; ___ Unknown
10. Hospital from which discharged:
11. Estimated distance between hospital and veteran's home:
    _____up to 25 miles _____101 to 200 miles _____301 to 500 miles
    _____26 to 100 miles _____201 to 300 miles _____over 500 miles
12. Diagnosis at time of discharge:_____
13. Occupation:_____ 14. Date of last employment:_____
15. Date of onset of TB:_____ 16. Date first hospitalized for TB:_____
17. Number of persons actually dependent upon veteran for support:_____
18. Number and dates of previous irregular discharges (indicate whether AMA or AWOL):_____
19. Number of previous regular discharges other than transfers:_____
20. See section B, for list of reasons for irregular discharges. Indicate the number (or numbers) of the reason (or reasons) for the current irregular discharge, as given in the record. If the record states a reason not listed in section B, fill in item 21.
    Record states number(s) _____ (was, were) reason(s) for irregular discharge.
21. Record states following was the reason for the irregular discharge:_____
22. Give pertinent details that will afford a more complete and clear statement of the answer given in item 20 or item 21:_____
    _____

B. List of Reasons for Irregular Discharge

(Refer to this list in completing items 20, 37, 57, 60 and 62)

23. Domestic or family problems (involving spouse, children, parents, sweetheart, etc.).
24. Job-employer-financial problems (not pension or compensation).
25. Withholding of disability pension or compensation.
26. Other pension or compensation problems.
27. Dissatisfaction with medical treatment.
28. Dissatisfaction with attitudes of or interest shown by hospital personnel.
29. Dissatisfaction with hospital rules and procedures (not medical treatment).
30. Influence or encouragement of persons outside hospital.
31. Immaturity or irresponsibility of veteran.
32. Failure to comprehend seriousness of physical condition.
33. Fear of surgery or other treatment techniques.
34. Feeling of despair, hopelessness about physical condition (but not dissatisfaction with hospital personnel or medical treatment).
35. Inability to find absorbing activities in hospital (boredom).
36. Veteran believed his leaving was not contrary to medical advice.

C. Reasons for Irregular Discharge from Veteran's Standpoint

37. *As the veteran sees it,* which one of the reasons listed in section B was the most compelling cause of the irregular discharge? If two or more of these reasons were *equally* responsible, in the veteran's judgment, indicate each. If the veteran believes that a reason other than those listed in section B was among the most compelling causes, fill in item 38.
    Veteran believes number(s) _____ (was, were) the most compelling reason(s) for the irregular discharge.

38. Veteran believes following (was, was among) the most compelling cause(s) of the irregular discharge_____
39. Give pertinent details that will afford a more complete and clear statement of the answer given in item 37 or item 38 and will point up areas in which changes in VA policy or procedures may be indicated. Identify reasons referred to; give appropriate number if reason is listed in section B_____
_____
40. What reasons are given in the record (items 20 or 21) that were not volunteered by the veteran during the interview?_____
_____
41. After discussion, does the veteran admit or deny the validity of the omitted reasons?_____

D. Present Physical Condition

42. Does the veteran say that he is feeling better, worse, or about the same as when he left the hospital?
___Much better ___About the same ___Much worse
___Better ___Worse
43. Is there any reason for questioning the veteran's statement about his physical condition? If so, describe:_____
44. Does the veteran wish to return to a hospital at the present time or in the near future? ___Yes ___No ___Veteran not sure
45. Which hospital? ___Same one ___Non-VA hospital
___Different one, but VA ___No preference
46. Has the veteran been receiving medical treatment for TB since leaving the hospital? If so, state nature of the treatment and name and address of the doctor, hospital, or clinic_____

E. Veteran's Attitude Toward Irregular Discharge Episode

47. Does the veteran now think he did the right thing in leaving?
___Yes ___No ___He is uncertain
48. From the veteran's point of view, what could have been done by VA that would have prevented the irregular discharge?_____
49. From the veteran's point of view, what could have been done by his family, friends, or other persons or agencies outside VA that would have prevented the irregular discharge?_____
50. Does the veteran feel that he has improved the situation responsible for his leaving the hospital, or does he now feel that he should have remained?
___He improved the situation ___He made the situation worse
___He was not able to improve it ___Question does not apply

F. Veteran's Situation After Leaving Hospital

51. Indicate where veteran went after leaving hospital (e. g. his own home, boarding house, home of friends, etc.):_____
52. State approximate age of each member of the household in which the veteran is living:
53. Does he think that anyone in the house or neighborhood is avoiding him or showing fear of contact with him?_____
54. Does the home provide a reasonably sanitary environment for the veteran?
___Yes ___No
55. Does the veteran observe proper sanitary precautions to avoid infecting others, particularly children? If yes, what precautions? If no, give details, explaining why not_____
56. Hours of bed rest observed by veteran each 24 hours: average since leaving hospital___: amount during last 24 hours___.

G. Summary Judgment of Social Worker

57. *In your judgment,* which one of the reasons listed in section B was the most compelling cause of the irregular discharge? If two or more of these reasons were *equally* the most compelling causes, in your judgment, indicate each. If you believe that a reason other than those listed in section B was among the most compelling causes, fill in item 58.
In my judgment, number(s) _____ (was, were) the most compelling reason(s) for the irregular discharge.

58. In my judgment, the following (was, was among) the most compelling cause(s) of the irregular discharge: ----------
59. Give pertinent details that will afford a more complete and clear statement of the answer given in item 57 or 58 and will point up areas in which changes in VA policy or procedure may be indicated. Identify reasons referred to; give appropriate number if reason is listed in section B ----------
60. Reasons for the irregular discharge which were of secondary importance: indicate appropriate numbers, if these reasons are listed in section B. If the reasons of secondary importance are other than those listed in section B, state the reasons: ----------
61. Give pertinent details for the answer given in item 60. ----------
62. Reasons for the irregular discharge which were of minor significance only: indicate appropriate numbers, if these reasons are listed in section B; otherwise state the reasons. ----------
63. What steps within the framework of existing regulations, policies, and procedures of VA do you think could have been taken that might have prevented the irregular discharge in this particular case?----------
64. What regulations, policies, and procedures do you think need reconsideration in the light of the causes of the irregular discharge in this particular case? ----------
65. Use this space if additional space is required for any of the preceding items. Identify the item by number. ----------

Signature of the interviewer:

Name of field station:

Location:

INCIDENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

REPORTS FROM STATES FOR WEEK ENDED OCTOBER 16, 1948

Summary

A net decline of 85 cases was recorded during the week in the incidence of poliomyelitis—from 1,207 last week to 1,122 for the current week—as compared with 1,042 cases for the corresponding week of 1946 (representing a decline of 100 cases) and a 5-year (1943–47) median of 549. Of the 21 States reporting currently 10 or more cases, 10 reported a decline of 112 cases, 2 showed no change, and 9 reported an increase from 513 to 574, chiefly in Wisconsin (35 to 57), California (223 to 234), South Dakota (58 to 66), and Missouri (14 to 21). Of 21,165 cases reported since March 20 (average date of seasonal low incidence), 15,966 (75 percent) occurred in 14 States grouped as follows (corresponding figures for 1946, 12,133, or 60 percent of the total, in parentheses): Middle Atlantic States 2,426 (1,469), 7 North Central States 5,494 (7,939), Virginia and North Carolina 2,801 (186), Texas 1,531 (818), and California 3,714 (1,721).

Of 2,010 cases of influenza reported (last week 1,493, 5-year median 1,388), Texas reported 962, Virginia 399, South Carolina 354, and Arkansas 114. For the corresponding week last year the same States reported an aggregate of 1,706 of the total of 1,956 cases.

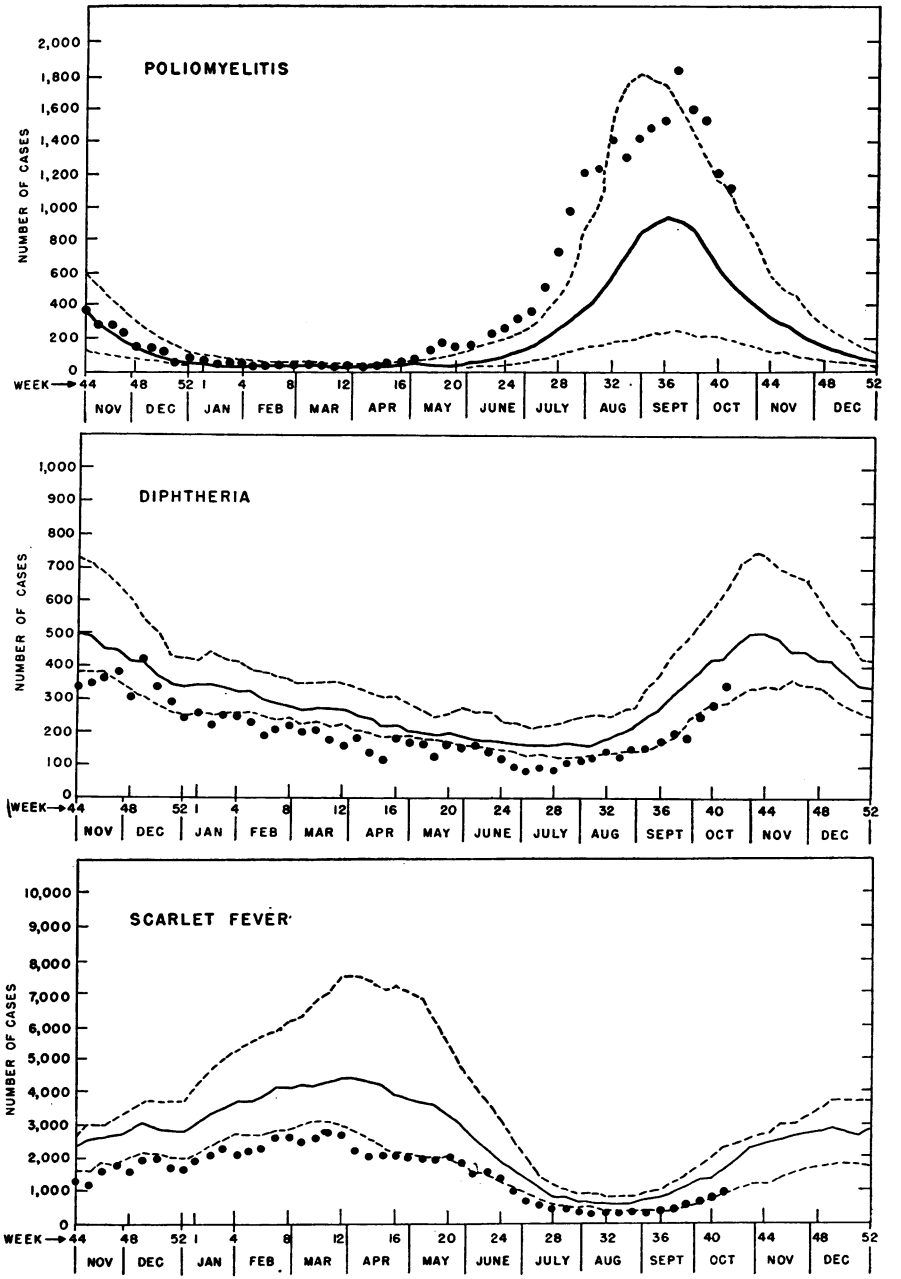
The current total of 1,320 cases of measles, and the cumulative figure 5,216 since the average seasonal low date (September 4) are above the corresponding figures of the past 4 years. The 5-year medians are, respectively, 814 and 3,725.

Other reports for the week include 5 cases of Rocky Mountain spotted fever, 2 each in Virginia and North Carolina and 1 in Oregon; 2 cases of psittacosis, 1 in Pennsylvania and 1 in California, and 1 case of smallpox, in Mississippi.

Deaths recorded for the week in 93 large cities in the United States totaled 8,498, as compared with 8,385 last week, 8,780 and 8,743, respectively, for the corresponding weeks of 1947 and 1946, and a 3-year (1945–47) median of 8,780. The total for the year to date is 385,764, as compared with 385,797 for the same period last year. Infant deaths totaled 630, last week 597, 3-year median 703. The cumulative figure is 27,936, as compared with 31,084 for the same period last year.

Communicable Disease Charts

All reporting States, November 1947 through October 16, 1948



The upper and lower broken lines represent the highest and lowest figures recorded for the corresponding weeks in the 7 preceding years. The solid line is the median figure for the 7 preceding years. All three lines have been smoothed by a 3-week moving average. The dots represent numbers of cases reported for the weeks of 1948.

Telegraphic case reports from State health officers for week ended Octobev 16, 1948

(Leaders indicate that no cases were reported)

Division and State	Diphtheria	Encephalitis, infectious	Influenza	Measles	Meningitis, meningococcal	Pneumonia	Poliomyelitis	Rocky Mt. spotted fever	Scarlet fever	Smallpox	Tularemia	Typhoid and paratyphoid fever [d]	Whooping cough	Rabies in animals
NEW ENGLAND														
Maine				153		4	1		14				4	
New Hampshire				9									9	
Vermont			2	24					3				1	
Massachusetts	7			110	2	21	9		56			3	34	
Rhode Island						1						1	7	
Connecticut	1			8	3	32	5		15				14	
MIDDLE ATLANTIC														
New York	6		(b)	58	5	170	66		[c] 70			1	64	8
New Jersey			1	37	1	41	42		16				36	1
Pennsylvania	8		(b)	25	5		29		71			2	50	5
EAST NORTH CENTRAL														
Ohio	3		1	7	3	23	38		89			4	21	6
Indiana	9			2	1	11	12		18			6	4	13
Illinois	1	1	1	15	4	61	74		65		2	3	19	2
Michigan [a]	9			46	1	23	24		44			9	19	1
Wisconsin			16	76	3	2	57		12				16	
WEST NORTH CENTRAL														
Minnesota	1	1		11			79		26				2	
Iowa	2			1			61		11				19	
Missouri	15		4	6	1	11	21		18			2		
North Dakota	1	1		67			4		8			1		
South Dakota			1	1			66		1					
Nebraska	1		11	3		2	50		13			1	3	
Kansas	3		2	4	1	2	10		12				1	
SOUTH ATLANTIC														
Delaware							1		1			1		
Maryland [a]	1	1	2	27		26	10		[c] 10			2	8	
District of Columbia	2					5	7		3				8	
Virginia	9		399	44		28	22	2	26			3	25	2
West Virginia	7		11		3	1	4		18			4	6	
North Carolina	21			6	1		43	2	31		1	3	16	
South Carolina	36		354	7		71	8		7			1	21	4
Georgia	36		6	3	1	5	4		24			3	5	2
Florida	12		8	28		9	8		9			1	12	8

EAST SOUTH CENTRAL														
Kentucky	13		1		1	10	7		33			9	18	18
Tennessee	16		12	9	2	29	12		39			2	15	
Alabama	47		11	24		17	6		29			1	2	3
Mississippi [a]	18		4	2	2	4	1		9	1				
WEST SOUTH CENTRAL														
Arkansas	6		114	7		9	4		8			1	12	
Louisiana	1			4	1	1	8		5			12		
Oklahoma	3		9	1	1		3		8					3
Texas	35		962	255	6	131	32		17		2	11	64	24
MOUNTAIN														
Montana			6	9			5		10				2	
Idaho			5	4		2	1		[c] 4					
Wyoming				13					3					
Colorado	1		29	21			6		10			3	9	
New Mexico				1		5	4		1			3		
Arizona	6		23	8		6	5		5			4	4	1
Utah [a]	1			11			2		4		3		12	1
Nevada							2							
PACIFIC														
Washington				37	4	3	26		38				3	
Oregon	4		12	60		9	[1] 9	1	6				11	
California	2	2	3	84	6	18	234		51			1	30	2
Total	344	6	2,010	1,328	58	793	1,122	5	971	1	8	98	606	
Median, 1943–47	415	10	1,388	814	75		549	2	1,565	2	14	101	1,566	
Year to date, 41 weeks	7,031	471	150,301	556,638	2,615		[1] 21,515	506	60,438	53	784	2,930	64,300	
Median, 1943–47	9,865	521	198,538	546,291	6,845		10,845	445	108,609	297	677	4,063	100,909	
Seasonal low week ends	(27th) July 10		(30th) July 31	(35th) Sept. 4	(37th) Sept. 18		(11th) Mar. 20		(32d) Aug. 14	(35th) Sept. 4		(11th) Mar. 20	(39th) Oct. 2	
Since seasonal low week	2,421		11,486	5,224	179		[1] 21,165		4,822	3		2,457	1,377	
Median 1943–47	3,552		8,341	3,725	350		10,448		9,121	17		3,439	3,373	

[a] Period ended earlier than Saturday.
[b] New York City and Philadelphia only, respectively.
[c] Including cases reported as streptococcal infections and septic sore throat.
[d] Including paratyphoid fever and salmonella infection; currently reported separately, as follows: Massachusetts (salmonella infection) 3; New York (salmonella infection) 1; Michigan, (salmonella infections) 4; Georgia 1; Kentucky 1; Texas 10.

[1] Corrections: Poliomyelitis, delayed report, Oregon, 7 cases.

Psittacosis: California 1; Pennsylvania 1.
Alaska: Pneumonia 3.
Territory of Hawaii: Measles 46; whooping cough 1. Correction: week ended Oct. 9, add: lobar pneumonia 2; scarlet fever 1.

TERRITORIES AND POSSESSIONS

Puerto Rico

Notifiable diseases—4 weeks ended September 25, 1948.—During the 4 weeks ended September 25, 1948, cases of certain notifiable diseases were reported in Puerto Rico as follows:

Disease	Cases	Disease	Cases
Chickenpox	1	Syphilis	229
Diphtheria	44	Tetanus	8
Dysentery	5	Tetanus, infantile	1
Gonorrhea	183	Tuberculosis (all forms)	947
Influenza	543	Typhoid fever	4
Malaria	84	Typhus fever (murine)	6
Measles	175	Whooping cough	91
Poliomyelitis	4		

PLAGUE INFECTION IN SALT LAKE COUNTY, UTAH

Under date of October 14, plague infection was reported proved in fleas from rodents collected in Salt Lake County, Utah, as follows: A pool of 39 fleas from 2 ground squirrels, *Citellus variegatus*, trapped September 21 ⅕-mile south of the mouth of Heights Canyon along Wasatch Boulevard, Salt Lake City, and in 1 flea from a white-footed mouse, *Peromyscus maniculatus*, trapped September 22 along road in Millcreek Canyon 1 mile east of Evergreen Picnic Grounds.

DEATHS DURING WEEK ENDED OCT. 9, 1948

[From the Weekly Mortality Index, issued by the National Office of Vital Statistics]

	Week ended Oct. 9, 1948	Corresponding week, 1947
Data for 92 large cities of the United States:		
Total deaths	7,692	8,463
Median for 3 prior years	7,882	
Total deaths, first 41 weeks of year	347,974	346,242
Deaths under 1 year of age	540	657
Median for 3 prior years	670	
Deaths under 1 year of age, first 41 weeks of year	25,594	28,483
Data from industrial insurance companies:		
Policies in force	70,838,157	67,094,946
Number of death claims	11,508	10,557
Death claims per 1,000 policies in force, annual rate	8.5	8.2
Death claims per 1,000 policies, first 41 weeks of year, annual rate	9.3	9.3

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended September 25, 1948.—Cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	Brit. Columbia	Total
Chickenpox		4		20	62	18	9	36	25	174
Diphtheria				8	7		1	5	1	22
Dysentery:										
Amebic					1					1
Bacillary				6	1					7
Encephalitis, infectious							1			1
German measles				1	3			3	6	13
Influenza		105			7	2			3	117
Measles		1		38	47	5	5	7	14	117
Mumps		1		24	48	31	9	13	8	134
Poliomyelitis		3		3	27	10	2	24	2	71
Scarlet fever			8	23	18	2	7	2	5	65
Tuberculosis		3	6	72	30	15	3	6	75	210
Typhoid and paratyphoid fever			1	10		1				12
Undulant fever			1	1					1	3
Venereal diseases:										
Gonorrhea		16	7	124	91	45	22	43		348
Syphilis	14	11	14	53	42	9	2	5		150
Whooping cough				103	24	4	9	5	1	146

CUBA

Habana—Communicable diseases—4 weeks ended September 25, 1948.—Certain communicable diseases were reported in Habana, Cuba, as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Diphtheria	6		Tuberculosis	2	1
Measles	7		Typhoid fever	13	1

Provinces—Notifiable diseases—4 weeks ended September 25, 1948.—Ccertain notifiable diseases were reported in the Provinces of Cuba:

Disease	Pinar del Rio	Habana [1]	Matanzas	Santa Clara	Camaguey	Oriente	Total
Cancer	1	19	11	25	4	26	86
Diphtheria		7					7
Hookworm disease		22					22
Leprosy		5				4	9
Malaria	2	4			4	8	18
Measles		7	1		1		9
Tuberculosis	3	8	14	24	14	16	79
Typhoid fever	7	22	2	14	5	24	74
Typhus fever (murine)		1	1				2
Whooping cough	2						2

[1] Includes the city of Habana.

JAPAN

Japanese "B" encephalitis.—During the week ended September 25, 1948, there was a sharp reduction in Japanese "B" encephalitis in Japan—286 cases with 133 deaths were reported for the week as compared with 499 cases, 162 deaths, during the preceding week. Through September 25, 1948, a total of 8,047 cases had been reported, with 2,197 deaths, as compared with 198 cases and 94 deaths for the same period in 1947.

NEW ZEALAND

Notifiable diseases—4 weeks ended August 28, 1948.—During the 4 weeks ended August 28, 1948, certain notifiable diseases were reported in New Zealand as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Cerebrospinal meningitis	9	3	Malaria	1	----
Diphtheria	26	----	Poliomyelitis	84	4
Dysentery:			Puerperal fever	5	----
Amebic	7	----	Scarlet fever	103	1
Bacillary	10	----	Tetanus	1	2
Erysipelas	14	1	Tuberculosis (all forms)	193	45
Food poisoning	1	----	Typhoid fever	5	----
Influenza	3	3	Undulant fever	1	----
Lethargic encephalitis	3	2			

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual incidence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during recent months. All reports of yellow fever are published currently.

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

Cholera

India.—During the week ended October 2, 1948, 133 cases of cholera were reported in Madras and 42 cases in Calcutta. During the same week cases were reported in other ports (sea or air) as follows; Allahabad, Bombay (imported), Cawnpore, and Cuddalore.

Pakistan.—During the week ended September 25, 1948, 28 cases of cholera were reported in Lahore.

Plague

China.—An outbreak of plague has been reported in Hsiakwan, 420 kilometers west of Kunming, on the Burma Road, with 12 cases and 5 deaths up to October 15.

Peru.—During the week ended October 2, 4 cases of plague with 2 deaths were reported in Lima, Peru.

Smallpox

Colombia.—During the month of August 1948, 27 cases of smallpox were reported in Medellin, Colombia, and during the 2 weeks ended September 19, 9 cases were reported in that city.

Iraq.—During the week ended October 2, 1948, 18 cases of smallpox were reported in Iraq, of which 5 cases occurred in Bagdad.

Typhus Fever

Colombia.—During the month of August, 28 cases of typhus fever with 1 death were reported in Medellin, and for the 2 weeks ended September 19, 17 cases with 1 death were reported.

Egypt.—During the week ended October 2, 1948, 16 cases of typhus fever were reported in Alexandria and 2 cases in Port Said.

Greece.—During the week ended October 3, 1948, 13 cases of typhus fever were reported in Greece.

Libya.—During the week ended September 24, 1 case of typhus fever was reported in Tripoli, Libya.

Turkey.—During the week ended October 2, 1948, 10 cases of typhus fever were reported in Turkey, including 2 cases in Izmir, 1 case in Sinope, and 1 case in Istanbul.

Yellow Fever

Peru.—On July 23 a death from yellow fever was reported as having occurred in Tingo Maria, Huanuco Province, Peru, in November 1947 and not previously reported.

Vaccination Requirements For Air Travelers to Australia

The Commonwealth Quarantine Act has been amended to provide that all persons arriving by air in Australia must produce a valid Vaccination Certificate. Persons not producing such a certificate will be vaccinated at the first port of entry and be subject to surveillance or other restrictions considered necessary. All aliens who apply for visas for Australia and who are to travel by air must produce certificates of vaccination before visas are granted.

The Australian Department of Health requires that certificates of vaccination to be acceptable must (1) be issued or endorsed by a medical officer of a Department of Health of the country in which the certificate was issued; (2) be issued in respect of a vaccination within three years before the date of their arrival in Australia; (3) indicate that the reaction to the vaccination has been examined by a medical officer; (4) indicate which of the following types of reaction was shown by the examination: (a) Primary Jennerian Reaction or Typical Primary Reaction; (b) Accelerated Reaction (Vaccinoid); (c) Reaction of Immunity. A certificate stating "No Reaction" will not be accepted.